The Canadian Nurse

Registered at Ottawa, Canada, as second class matter.
Editor and Business Manager:
ETHEL JOHNS, Reg. N., 1411 Crescent Street, Station H, Montreal, P.Q.

CONTENTS FOR NOVEMBER, 1943

Subscription Price: $2.00 per year; foreign and United States of America, $2.50; 20 cents a copy.
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Reader's Guide

The Future of Nursing Education is giving rise to lively speculation these days and, with the kind permission of "The Modern Hospital", we are privileged to reprint in this issue a challenging article by Dr. Hugh Cabot which has given rise to animated discussion both for and against. In an editorial entitled "Where do we belong?" you will find some comments which may or may not seem to you to be pertinent. Take a look at them and then tell us what you think.

The task of a hospital administrator is never an easy one and in time of war becomes more than usually difficult. **Edith Young** is the very capable superintendent of the Nicholls Hospital, Peterborough, Ontario, and knows whereof she speaks. Her article is the substance of an address, given at a meeting of the Registered Nurses Association of Ontario, which created an excellent impression.

Canada is a young country and it is therefore a notable event when any institution celebrates its centenary. The *Journal* is proud to publish **A Hundred Years of Maternity Nursing** and is very grateful to Caroline V. Barrett for giving its readers such an interesting glimpse of the early days in the Royal Victoria Montreal Maternity Hospital, of which she is now the supervisor. This article brings to a close the admirable series on obstetrical nursing prepared by Miss Barrett and her colleagues for the *Journal*. The history of the next hundred years of maternity nursing is off to a good start under their capable direction.

Although nurses have not as yet fully realized the importance of the field, they are showing much more active interest in mental nursing than was formerly the case. **Dr. Robert O. Jones** not only gives an excellent description of the use of electric shock therapy but also points out the desirability of treating certain forms of mental disease in general hospitals. Dr. Jones is associate professor of psychiatry at Dalhousie University, Halifax, N.S.

The gallant "come back" made by our married nurses has literally saved the day in many a busy hospital. **Mrs. J. A. Russell** is a member of this group and, in describing her own experience, suggests a few adjustments that might help to make things easier for all concerned.

So many students are taking postgraduate courses in the departments of nursing of our Canadian universities that it is difficult to plan their field experience. **Geraldine Langton and Isabelle Chodat** give a detailed and stimulating description of how this situation was dealt with in British Columbia. Mrs. Langton is field work supervisor in the Department of Nursing and Health of the University of British Columbia and Miss Chodat is co-ordinator of nursing service of the Vancouver Metropolitan Health Committee.

Notes from the National Office should be read with close attention this month; they contain a number of recommendations presented to the Executive Committee of the Canadian Hospital Council, prepared by the special committee appointed for that purpose by the Canadian Nurses Association. These recommendations deal with certain aspects of nursing service that evidently stand in need of adjustment. The C.N.A. special committee on postgraduate work has also formulated an outline of standards that will serve as a useful guide in institutions where such courses are offered.

At a time when the problem of giving proper care to patients suffering from tuberculosis is giving rise to considerable anxiety, it is most heartening to learn about the work of the Samaritan Club of Toronto. **Helen Larkin** is case worker for the Club and offers a convincing and moving appeal on behalf of men who stand in need of more understanding and help than is usually afforded them. Miss Larkin is herself a nurse and has taken the course in public health offered by the School of Nursing of the University of Toronto.

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The
CANADIAN NURSE

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PUBLISHED BY THE CANADIAN NURSES ASSOCIATION
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Where do We Belong?

During the past two years nursing and nurses have received more attention from the community at large than ever before. In the newspapers, over the radio, on the screen the merciless spotlight of publicity is shed upon us whether we like it or not. In Canada and in Britain, and most of all in the United States, people are asking: What service have we the right to expect from professional nurses and how should they be prepared to render it effectively? To say that there is confusion in the answers given to these questions is to put it mildly. They range all the way from frankly reactionary to radical suggestions for enlarging the nursing field which are a bit terrifying even to our most daring leaders. So far, nurses themselves do not speak with one voice and we have a long way to go before we can offer any clear and practical blueprint of what we consider to be our manifest destiny.

In the meantime, the public at large is naturally getting a bit impatient and suggestions pour in from every side. Some of these come from those members of the medical profession who say that all this nonsense about educating nurses ought to stop and that we can be taught all we need to know in six months. On the other hand, there are also a few forward-looking men who suggest that many of us should cease to be nurses at all and should become an integral part of the practice of medicine. With the kind permission of the editor of *The Modern Hospital* a challenging article, written by Dr. Hugh Cabot on this subject, is reprinted in full in this issue of *The Canadian Nurse*. Every reader therefore has the opportunity of interpreting it in terms of her own background and experience. The following comments are simply a personal reaction and must be taken only for what they are worth.

Dr. Cabot contends that it is futile to expect that physicians can be induced to enter the public health field in suf-

ficient numbers to meet the growing demand and is evidently sincerely convinced that much of the work could be done better by women than by men. Briefly stated, his plan is that the public health nurse shall cease to be a nurse and shall become "*almost* a capable practitioner of preventive medicine." The italics are ours and are used deliberately because the word "almost" is highly significant in this connection. It makes it clear that this woman will not be a fully qualified physician but is to be a member of a newly-created Minor Order of the medical hierarchy. Her preparation would be shorter and less expensive and her duties would be correspondingly limited. She would be almost a doctor — but not quite.

Dr. Cabot recommends that the scope of her duties should be much broader than that of the public health nurse. She would be "something approaching an expert on the problems of nutrition" and would be "more involved with the practice of medicine than is the trained nurse of today". He points out that the average hospital school of nursing cannot be expected to prepare these workers because the present three-years course tends to produce specialists who, while essential to the modern practice of medicine, are nothing more than "invaluable assistants and associates of physicians".

Furthermore, Dr. Cabot evidently has some doubt as to whether schools of public health nursing (as at present constituted) can fill the bill. He suggests that nursing education should be placed on an academic basis "in well established universities which already have, as part of their organization, medical schools and hospitals". Incidentally he is apparently not aware that these conditions already exist in several schools of nursing, among them the School of Nursing of the University of Toronto. Is it possible, therefore, that the sort of education he is seeking for these workers is already available and could be broadened and strengthened until it fulfils their every need? These women would then be entitled to receive an advanced degree in nursing and would be qualified to collaborate, on equal terms, with physicians in the public health field.

Unfortunately it is not made clear why Dr. Cabot considers it advisable that these workers should be minor practitioners of medicine rather than major practitioners of nursing. Obviously they would be more readily controlled if they were licensed by medical authority and granted a minor academic degree, and nurses would have no right to be critical of such an approach since we ourselves have proposed a comparable method of dealing with the trained attendant.

The point at issue seems to be this — is it desirable to set a limit beyond which nursing may not progress? Once a certain level is reached, must we leave nursing behind and enter a Minor Order of medicine? If the answer is yes, we had better put aside all thought of nursing as an emerging profession and begin to think of it as a highly skilled handicraft — nothing more, but nothing less.

A profession, like a nation, cannot exist half bond and half free and, if we had to make a choice tomorrow morning between nursing (even as a handicraft) and membership in a Minor Order of the medical profession, we should choose nursing. At least we should be independent and therefore free to explore every new avenue that presented itself. Some handicrafts have even earned the right to recognition as a profession — for example the barber surgeons. In the meantime, we should not be *almost* practitioners of medicine. We should be nurses — and proud of it.

— E. J.

The Future of Nursing Education

HUGH CABOT, M. D.

The professional services rendered by physicians and nurses are essential social services. They must be closely integrated with contemporary social conditions and very sensitive to social change.

One does not have to be a prophet to advance the opinion that great social changes have taken place in this country and that still more fundamental changes lie immediately before us. From this it seems to me to follow that unless the professions of medicine and nursing so plan their educational offerings as to keep at least in step with social change they are likely to fail the country in the time of its greatest need.

The present day nursing education with the three-year hospital course leading to a R. N. is essentially patterned upon the status of medical practice during the last twenty-five years. In the earlier days of the training schools for nurses the graduates were trained for the private practice of nursing. Much of their time after graduation was spent in home nursing and, as compared with the present day, relatively little in hospital nursing except in administrative positions.

The rapid increase in the utilization of hospitals, for both diagnosis and treatment, has enormously increased the demand for hospital graduate nursing and with this has come a great decrease of the utilization of nurses for home care. The present standard three-year course in nursing produces specialists essential to the modern practice of scientific medicine. In many respects these graduates are junior practitioners of medicine and invaluable assistants and associates of the physicians. Just as an increasing amount of the practice of medicine is carried on in and about hospitals so an even greater amount of the practice of nursing is carried on in the same environment. There is no probability that this demand for hospital nurses will diminish; in fact, it is likely to increase and thus the demand for women with this type of training must continue to be met.

But no one can have lived in close touch with our changing social conditions without having noted that there is clearly evident a change in the accent on medical practice with an increasing shift from diagnosis and treatment to prevention and positive health. We have come to realize that, though the diagnosis and treatments of illness is an essential requirement of medical practice, the maintenance of a healthy population and the use of the scientific possibilities that have been placed at our disposal will require of the medical profession, in the immediate future, thorough application of preventive medicine in all its ramifications, much more attention to nutrition and other sound principles of living and much more interest in positive health than has been the case in the past. This will constitute an enormous addition to the burden already carried by physicians and their associates and will obviously require a large increase in personnel.

At first sight it might seem as if this increase would have to be largely in the number of physicians and in their more satisfactory distribution. On the other hand, modern medical education requires a long and expensive training and we shall be well advised to consider whether such an increase is either necessary or desirable. Much of the work that will be added — I think, in the immediate future — will consist of the

collecting of fact, the giving of instruction and general supervision of living conditions without which no sound program of health can succeed. I am firmly of the opinion that much of this work can be done not only as well but better by women with an appropriate training. But I do not think that the present training, aimed as it is chiefly to produce experts in hospital nursing, will fill the bill.

What I have in mind will come under the general heading of public health nursing though it will not, as I think, correspond accurately with the work now done by nurses trained in public health schools. The nurses, of whom there should be in my judgment a large number, should have a training much broader than is now given to the candidate for hospital nursing. It should be less special, should cover much more of the field of preventive medicine, provide much more familiarity with normal health, and it must provide a sound background in the understanding of social conditions. Such training cannot easily be articulated with the present standard course given in hospitals, which is still considerably on an apprentice basis.

The nurse who is to participate largely in the newer programs of preventive medicine and positive health will have to know something more of the fundamentals of medical practice. She will have to be something approaching an expert on the problems of nutrition. She will have to know a great deal of the problems of social adjustment, of personality problems, of the methods of adjusting children — those newcomers into a strange world — to their environment, and she will have to be almost a capable practitioner of preventive medicine. Much of her time will probably be spent in the home of the patient studying the conditions, familiarizing herself with the personalities of the family and advising as to how a meager income may be made to supply a satisfactory environment for normal healthful living.

I have long believed that women are, on the whole, better suited than men to studying environment, giving the appropriate advice and feeling their way along deftly in complicated and varying conditions of environment. All these things used to be done in a simpler world by the general physician, but it is many years since the increasing burden placed upon the physician by modern science has made such a role for him possible. Moreover, our knowledge in all of the fields broadly covered by the phrase "preventive medicine" has increased to such an extent that, with proper and detailed supervision, much disease can be permanently avoided and many conditions which are not properly described as disease but which undermine health and diminish working capacity can be headed off and replaced by positive health. However, these things cannot be done by the personnel now available.

I make bold, therefore, to suggest that here is an essential field for which women with a sound training are peculiarly fitted. I would even go further and suggest that, unless some such development takes place, care of the health of the people that is thoroughly in step with modern scientific knowledge cannot be given.

Here, then, is the requirement not for the creation of a new profession but for the extension of the work now being done by nurses commonly thought of as working in the field of public health. As already suggested, I do not think that appropriate training can be provided with the machinery now at our disposal. I am convinced that this training should be placed, where many believe nursing education should long since have been placed, on an academic basis. The schools that should give this training will, I think, as a rule, have to be parts of well-established universities which already have as part of

their organization, medical schools and hospitals.

I should be hopeful that a carefully planned course could be compressed into four years though there will be great temptation to try to put such a training on top of that now offered in the hospitals. This would, I think, be a mistake and will make it difficult to avoid waste of time and loss of balance and to provide a well-rounded, because single-minded, educational plan.

As I have already suggested, these people will be even more involved in what is properly regarded as the practice of medicine than are the trained nurses of today. We, in this country, (the United States) have made but little use of the degree Bachelor of Medicine. This would, I believe, be an appropriate indication of their relation to medical service as a whole. It would suggest that they did not have the elaborate scientific equipment of the physicians but, at the same time, would make it abundantly clear that they were involved in the practice of medicine and were essential cogs to anything approaching complete medical care in step with modern science.

I think this problem is urgent for I am convinced that we shall find ourselves in the postwar period with an urgent demand for great extension of medical care and a supply of physicians and nurses who are not equipped by training or experience to carry out successfully important parts of the schedule. I am aware that the setting up of such schools cannot be done overnight, that it is not every university that can provide the equipment and environment and that there are still fewer that could face with equanimity the expense involved. I, therefore, humbly suggest that this is a major problem for the U. S. Public Health Service and that funds to start and to maintain such schools will probably have to be provided by the federal government since I see no other agency that could set up the number of schools necessary and provide for their proper geographical distribution.

To those who believe that this is the vision of a starry-eyed idealist, I commend a thoughtful study of the evidence that the American people are ill-satisfied with the medical service now at their disposal, that there is an extraordinary unanimity of opinion at all levels to the effect that improvement of the service is long overdue, and that there is behind this conviction a weight of opinion that is likely to demand action.

Editor's Note: The *Journal* is greatly indebted to "The Modern Hospital" for permission to reprint this stimulating and provocative discussion of the future of nursing education. Dr. Cabot has been awarded the gold medal, given annually by "The Modern Hospital", to the author of the article which, in the opinion of the judges, was the most helpful and constructive to be published in that magazine over a period of twelve months.

The A.A.R.N. and the A.R.N.P.Q. Set a Good Example

The Alberta Association of Registered Nurses and the Association of Registered Nurses of the Province of Quebec are setting a good example that might well be followed by other nursing organizations to the great benefit of all concerned. Following the annual examinations for the title of Registered Nurse, each of these Provincial Associations awards a year's subscription to *The Canadian Nurse* to a given number of candidates who achieve the highest standing. These young nurses thus receive the *Journal* free of charge during the period when they need it most but are only just beginning to get themselves established financially.

A Hundred Years of Maternity Nursing

CAROLINE V. BARRETT

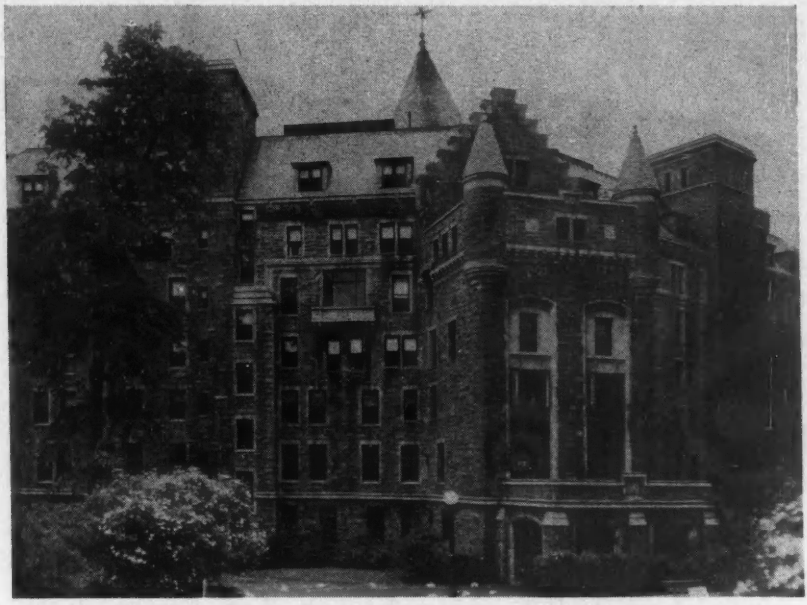
Just a hundred years ago, in November 1843, the University Lying-In Hospital was established in the city of Montreal. Its purpose, as defined in an early report, was to render charitable service and to provide for the instruction of the students of the Faculty of Medicine of McGill College in practical midwifery. This hospital was probably one of the first in America to offer clinical teaching in obstetrics for it was not until 1851 that such teaching was undertaken in the United States, under the direction of Dr. James F. White in Buffalo, N. Y. During the first year of its existence, 41 patients were admitted to the University Lying-In Hospital and, over a period of sixteen years, the yearly average was only 123. Yet, on its hundredth anniversary, it has developed into what is now known as the Royal Victoria Montreal Maternity Hospital, housed in a beautiful building on the southern slope of Mount Royal. In 1942, there were 2513 deliveries with a maternal death rate of only 1.5 per thousand births.

Photo by Jacoby, Montreal

CAROLINE V. BARRETT

Vision and wisdom guided the founding of the enterprise and, from the outset, a high standard of service has consistently been maintained. This was due in a large measure to the fact that the medical direction of the hospital has always been under the control of the professor who occupied the chair of obstetrics in McGill University. The following physicians have served successively as physicians-accoucheurs: from 1843 to 1854, Dr. Michael McCulloch; from 1854 to 1867, Dr. Archibald Hall; from 1867 to 1883, Dr. Duncan C. MacCallum; from 1883 to 1886, Dr. Arthur A. Browne; from 1886 to 1912, Dr. James Chalmers Cameron; from 1912 to 1929, Dr. Walter William Chipman; from 1929 to the present day, Dr. John R. Fraser. In 1913, the chairs of obstetrics and gynaecology were combined, Dr. Walter W. Chipman being the first to occupy this dual position. The Board of Governors of the Royal Victoria Hospital exercises control over the institution through its administrator, Dr. George F. Stephens. All matters relating to nursing are under the direction of Miss Fanny Munroe, superintendent of nurses and principal of the Training School.

Through the years, the name of the Hospital, as well as its location, has been changed several times. Originally called the University Lying-In Hospital, in 1884 it was named the "University Maternity Hospital", and in 1887 the "Montreal Maternity Hospital". When, in 1926, it was amalgamated with the



Royal Victoria Montreal Maternity Hospital

Royal Victoria Hospital, it became known under its present name of the Royal Victoria Montreal Maternity Hospital. From 1843 to 1847, the hospital was located at 91 Main St. in "the suburb of St. Lawrence". It was then moved to 78 St. Charles Borromée St. and later to St. Urbain St., where it remained from 1852 to 1926.

As early as 1844, in the year immediately following the establishment of the Hospital, a Ladies Committee of Management was appointed. Its officers were made responsible for the internal management of the Hospital as well as for its financial stability, and an amazing amount of work was done by these devoted women. This Committee continued to function until the Hospital was amalgamated with the Royal Victoria Hospital, and many of its members continue to be actively interested in the work of a new Committee which, under the guidance of Lady Meredith, carries on the fine tradition and excellent work of the group from which it sprang.

The officers of the first Ladies Committee of Management were elected in September, 1844. Its "first directress" was Mrs. Lunn; the "second directress", Mrs. (Dr.) Bethune; the "third directress", Mme Cuvillier. The treasurer was Mrs. Jacob Hall, and the secretary, Mrs. Dunkin. Fortunately the minutes of the meetings of the Committee have been preserved. They were beautifully written, in slanting Victorian handwriting, in leather-bound notebooks. Details of expenditure were meticulously set down and considerable attention was given to ways and means of raising money. The medical students took a lively interest in hospital affairs and in the minutes it is recorded that: "at the request of the students, it was unanimously resolved to have a Soirée, at which there would be dancing, in aid of the funds of the Hospital". That this

The Graduating Class of 1892, *Montreal General Hospital School for Nurses In the centre of the back row is the Lady Superintendent, Nora Livingston, and on either side are Dr. D. C. Kirkpatrick and Dr. W. F. Hamilton. At the extreme right in the front row is Emily Cooper and, beside her, Ann Colquhoun. Most of these nurses had some training at the Montreal Maternity Hospital.*

event was a grand success is shown by the following excerpt from the Montreal Gazette: "The Soirée, in aid of the Lying-In Hospital which took place at Donegana's on Thursday, the 11th of February 1847, proved to be the most brilliant, if it was not also the most numerously attended public ball of the season". This was the first Charity Ball and was attended by the staff of the Governor General. The net proceeds were £102.12.2½. Financial support came from many other sources such as an annual gift of £12 from the Gentlemen of the Seminary, and a donation of £25 from the City and District Savings Bank. Incidentally, this Bank still makes an annual contribution. Even in those early days, the importance of publicity was recognized and the first annual report was published in 1846 in both the English and French newspapers.

There is ample evidence in the annual reports that there was excellent co-operation between the Ladies' Committee of Management and the Medical Board. These women displayed a keen interest in the care of the patients and there are many references to the problems that arose from time to time. In 1876 there was a severe epidemic of smallpox and the following excerpt is taken from the minutes:

> In consequence of an outbreak of smallpox, the Committee, on advice of the physician-accoucheur, closed the institution for a period of five weeks. The first patient in whom this disease appeared was a poor woman from one of the suburbs of the city. She was promptly removed to the smallpox hospital, the other inmates were immediately vaccinated, and measures were adopted to prevent others from being affected by the contagion.

The necessity of keeping careful medical records was realized almost from the

beginning and Mr. Mark Workman was appointed medical registrar in 1851 and resigned in 1855. During this time he obtained his degree in medicine and later became "director of a Lunatick Asylum in the City of Toronto". The first reference to the delivery of patients in their own homes is made in the annual report for the year 1859 and reads as follows: "Of 107 deliveries, eight were delivered in their own homes by the matron (a midwife) or some of the gentlemen in attendance at the hospital and under the supervision of the physician-accoucheur".

During the interval between 1843 and 1885, eight midwives served successively as matrons of the Hospital. They appear to have done good work and it is fitting that their names should be recorded. Their tenure of employment was as follows: from 1843 to 1851, Mrs. Buchanan; from 1851 to 1852, Mrs. Smith; from 1852 to 1855, Mrs. Gibson; from 1855 to 1856, Mrs. Lockhart; from 1856 to 1861, Mrs. Hope; from 1861 to 1871, Mrs. McBride; from 1871 to 1879, Mrs. Hanna; from 1879 to 1885, Mrs. Smillie. Two of these women are known to have received some formal preparation for midwifery. Mrs. Smith was trained in Edinburgh, Scotland, and Mrs. Hope was designated as "a licensed midwife". The wages paid the midwives were far from extravagant even for those days although an occasional bonus was voted as the reward of faithful service. Mrs. Hanna died during her term of office and a sincere and moving tribute is made to her in the minutes. Her funeral expenses were defrayed by the Hospital.

In 1885 Mrs. Redmond was appointed matron but it is not known whether or not she was a midwife. In the following year, Miss A. Rideout (who was not a midwife) took charge and

A group of Royal Victoria Hospital student nurses who were among the first to take an affiliating course at the Montreal Maternity Hospital. Mabel Hersey is fourth from the left in the back row.

Photo by Dupras & Colas, Montreal

H. Louise Lewis

appears to have been a most capable woman. Her appointment synchronized with that of the first resident physician, Dr. H. Y. Grant. Miss Rideout submitted a monthly report to the Ladies Committee of Management that reflects the problems with which she was confronted. The following excerpt is fairly typical:

December, 1890. Five admissions only; twelve remaining; maximum seventeen. One death; four discharges; twelve remaining now. Another trying month. One patient died though everyone did their utmost for her. Two who ought to have gone a month before are still here, one with a sore breast (abscess); one had finger amputated. Neither of these cases were really such as we should nurse but, having babies, the General Hospital would not receive them and other institutions have no facilities to nurse such cases. There is great need in Montreal of a nursing mothers' ward in a hospital, or a special hospital for such cases. Our two isolated cases are both discharged, one cured and the other as nearly as she can ever be.

That Miss Rideout also had to solve domestic problems is shown by yet another excerpt from a monthly report:

The new cook is perfectly useless and excessively impertinent. She leaves the food half-cooked or burns it up and, when spoken to about it, replies rudely or cries. What *are* we to do? This miserable condition of things cannot be borne long! It would be cheaper possibly to pay a cook competent for her work and certainly would make a great difference in comfort. The hall matting is a disgrace to the place.

Miss Rideout's reports afford proof that she realized that a better type of woman should be prepared for the care of the sick. In 1886 it is recorded that six "nurses" received diplomas, the length of the course being one year. In 1887 two "nurses" received certificates of merit and a third, on completion of her training, was retained on the staff as a "permanent nurse". During 1888 and 1889, "maternity nurses" continued to be trained and in 1890 eight graduates of the School of Nursing of the Montreal General Hospital were accepted for a two-months' course. In the following year, this course was extended to three months.

It was in 1892 that, for the first time, a graduate nurse was appointed as matron. In that year, Emily Cooper, a graduate of the School of Nursing of the Montreal General Hospital, assumed this position and the Ladies Committee of Management later expressed itself as "having every reason to feel satisfied with the change". In one of her earliest reports, Miss Cooper notes with great satisfaction that "Nurse Ann Colquhoun has reported for duty". Miss Cooper remained in office until 1896 and during the next ten years, Miss A. E. Aikman, (now Mrs. Rutter), Miss Isabella Jewell, and Miss Frances Gage served successively as matrons. The records show that they met their problems courageously and did their best to maintain good standards. In 1906, Louise Lewis, a graduate of the School of Nursing of

the Royal Victoria Hospital, assumed office. Her nursing experience was very wide and included supervisory work in the Johns Hopkins Hospital, the Lakeside Hospital, Cleveland, and the Albany Hospital, Albany, N. Y.

A capable, dignified woman, Miss Lewis did much to raise the standard of nursing. In 1915 she was succeeded by Mary Ellen Snell, a graduate of the School of Nursing of the Toronto General Hospital, who held office until 1918 when Kathleen Cains (now Mrs. Hugh Hanson), a graduate of the School of Nursing of the New York Hospital, assumed direction. In 1920, Caroline V. Barrett, a graduate of the School of Nursing of the Montreal General Hospital, who had previously successively held the positions of night superintendent and assistant superintendent of the Montreal Maternity Hospital, was appointed to be superintendent. At the time of the amalgamation with the Royal Victoria Hospital she was named supervisor of the Royal Victoria Montreal Maternity Hospital and continues to hold this position. One of the outstanding members of the nursing staff is Islay L. Hiscox who, in various capacities, has rendered valuable service to the institution.

Even in this brief historical sketch, reference must be made to the service on the district which will always be remembered by nurses who received their training at the old Montreal Maternity. It was with a feeling of fear and trepidation that they heard the call for a home delivery. In those early days taxis were unknown, so the interne and the nurse started off on foot each carrying a bag with the equipment needed for the case. It was only when the home was very far away that streetcar tickets were issued to them. Later on, a Ford car, dubbed the "tin Lizzie", was considered a great advance and a real luxury although it sometimes proved to be a mixed blessing. One recalls a junior interne, hailing from the wilds of Ontario, who, when sent out on his first

"Tin Lizzie No. 2" with Dr. Cameron Stewart in the driver's seat.

case, found it very difficult to remember all he knew about obstetrics while at the same time trying to master the intricacies of a car. He could not even grapple with the unpronounceable French name of the street to which he was going, so it is little wonder that he seemed bewildered. The present writer has a vivid recollection of having stalled in a one-seat Ford on a busy intersection of the streetcar track on St. Denis Street, with an interne (whom we all called "Dad") trying to crank the car and get it started while two motor-men exchanged "bon mots" over our heads. However, the "tin Lizzie" and her successors, which later became very grand, have helped to save a great many lives and have certainly made it much easier for internes and nurses to continue this useful service.

In 1917 a Social Service committee was formed with Mrs. Robert Adair at its head. This committee did a marvellous piece of work and continued to function until 1926. The first social service worker was Miss Nutter who was succeeded by Mrs. Mabel Pridham, and later by Miss Mary Burke and Miss M. Manion. Miss G. Matthews was in charge from 1921 to 1943 and Miss C. Goodwin now occupies this responsible position. Previous reference has been made in *The Canadian Nurse* to the fine work of Miss Cecil Dawkins who was in charge of the outdoor department for twenty-eight years.

Great strides in the education of nurses have been made since the turn of the century. In 1903, the first mention was made of affiliation. The annual report for that year contained the following statement:

> In December of last year the long discussed arrangement between the Montreal Maternity and the Royal Victoria and Montreal General Hospitals was finally brought to a satisfactory conclusion. It was decided that the undergraduates of these Training Schools should take three months at the Maternity Hospital as an integral part of their three-years' course of training. These nurses receive regular instruction in obstetrical work and pass an examination at the Maternity Hospital a report of which is sent to their own hospital on their return.

This was the beginning of a new era in which nurses from affiliated schools of nursing received a three-months' course in obstetrical nursing during their three years of general training. During 1903 and 1904, seven students from the School of Nursing of the Montreal General Hospital, and seven from the School of Nursing of the Royal Victoria Hospital, completed their affiliating course. Mabel Hersey was a member of the first group from the R.V.H. and is mentioned in the records as "a most excellent nurse". In 1942, no less than 199 student nurses, drawn from the School of Nursing of the Royal Victoria Hospital and eight affiliated schools, learned how to give maternity nursing care skilfully and well. The undergraduate course of study has been enriched and teaching and supervisory methods have been modified and improved. Postgraduate courses are also offered and, during the past year, 27 registered nurses availed themselves of this opportunity for specialization.

For a hundred years, the "Montreal Maternity" has served the mothers of Montreal loyally and faithfully. As a teaching centre for medical men and nurses, its facilities are unequalled and the future gives promise of even greater effort and achievement.

Electric Shock Therapy of Psychosis

ROBERT O. JONES, M. D.

The purpose of this article is threefold: (1) to discuss the type of cases in which shock therapy is suitable; (2) to describe the various types of shock treatment with especial reference to electric shock treatment; (3) to describe the technique, dangers, and results of electric shock treatment with especial reference to the nursing care. I have felt that an attempt to do this would be of value for three reasons: first, because there are usually nurses who are dealing with such cases; secondly, because this is an important advance in the treatment of some of the most stubborn of illnesses; and thirdly, because I frequently see patients who have come because of some nervous illness, having been advised to do so by a nurse who has assured the patient that I will give some magical electrical treatment that will shortly put everything right.

I should like then, first, to discuss the kind of cases in which shock treatment is of value. This method of therapy is not a cure-all of mental disease: it is a specific type of treatment for a special form of sickness. In our experience of a year and a half of psychiatric practice in Halifax we have seen some 500 cases, and of these only about fifty have been considered suitable for shock treatment. Because the majority of this latter group have been admitted to hospital and treated there, the impression has grown that this is an all embracing treatment and perhaps also that it is the only kind of treatment a psychiatrist has to offer. Both these views are wrong. In point of fact, only one of ten cases consulting the psychiatric clinic receives shock treatment.

To indicate what the suitable cases are, leads me into a brief description of psychiatric classification. All types of mental illness can roughly be divided into two main groups. The first is the group which untrained persons describe as "just nervous" and are called neurotics. These are the individuals who have constant physical complaints, are jittery and irritable, but who are able to carry on community life safely and moderately satisfactorily. These people do not benefit from shock treatment and are not treated by this method except in rare instances.

The second large group includes those whom laymen call insane or crazy and who might be considered for commitment to an institution. It is in these cases that shock treatment is helpful. They are known as psychotics and may be further classified into two subdivisions. First, there are those whose psychosis is the result of actual brain change due to organic disease including syphilis, or to blows on the head, or may be caused by toxic processes, alcohol or drugs. The second sub-division is that group in which there is no such change or toxic process nor is there any disease of the brain or of any other bodily organ that we can find.

It is obvious that shock treatment in organic cases is useless; that leaves us then with the second sub-division of psychotics (in which there is no brain change) as being the field of usefulness of shock treatment. In this second sub-division there are two major types of mental diseases. The first is characterized by primary disturbance in the mood or spirits; the patient is either elated and very happy or else depressed and sad. A large number of these disturbances occur in the later years of life and are known as involutional or menopausal depressions. It is in this

type of illness that electric shock therapy has the best results, making it possible to say with assurance that about 80% of such cases will be well or greatly improved following a course of electric shock treatments that will take some three to four weeks.

Shock treatment was first introduced into psychiatry in 1932 when an Austrian psychiatrist, Sakel, noticed that occasionally in treating cases of drug addiction with insulin, some patients would, by accident, receive too much and go into coma. To his surprise, their mental symptoms improved and the idea developed of giving large doses of insulin and purposely producing coma. This method was first used with considerable success in the schizophrenic psychosis (dementia praecox) and is still indicated in that type of mental reaction. A year later a second Viennese psychiatrist, Meduna, felt that there was some antagonism between epilepsy and schizophrenia and that such cases improved if they had an epileptic convulsion. He searched for a way of producing artificial convulsions and started using injections of camphor. Later a drug, a camphor derivation, known as Metrazol, proved superior and came into common use in the treatment of schizophrenia. In 1937, Dr. A. E. Bennett, of the University Clinic at Omaha, showed that the results of such treatment were particularly good in the case of depressions and this type of therapy has been largely used for depressed cases. There were certain drawbacks to Metrazol, the chief of these being the patient's dread and fear of it. In 1938, two Italian workers, Cerletti and Bini, developed a method of producing the same type of convulsion, by means of direct electrical stimulation of the brain, which produced the same result and had the advantage of producing in practically every patient so complete a loss of memory for the period of the treatment that they were not afraid of it; this method has now largely superseded Metrazol.

Now let us turn our attention to electric shock treatments. These are indicated in individuals who are severely depressed, or who are elated and overactive as, for example, the manic depressive psychosis and involutional melancholia. It is also of some value in schizophrenia if used early in the course of the illness. Treatments are given two or three times a week, generally in the morning, the patient having had no breakfast and preferably no sedative the previous night.

The patient is prepared for treatment by emptying the bladder and rectum and by having tight clothing and metal hairpins removed. He is postured in a position of hyperextension in the dorsal region by means of a pillow placed in the small of the back and is held in this position by assistants who fix the shoulders and pelvis firmly. The object of this is to limit movement of the spine in an attempt to prevent the most common complication, fracture of a dorsal vertebra. In some clinics a further step is taken to prevent fracture — the injection of a solution of curare intravenously before the shock is given. Curare is a South American drug which causes a temporary muscular paralysis and the force of the convulsion obtained is thus very much softened and traumatic damage is rare. The drug is given intravenously in doses of 3 to 5 c. c.

A minute or so later the shock is given. The patient immediately loses consciousness in all cases and one of two results occur, named because of their resemblance to the epileptic convulsion: (1) the *petit mal* response — a loss of consciousness for only a few seconds with no convulsion, the patient being dazed and bewildered for short time after; (2) the *grand mal* response which is exactly like the epileptic sei-

zure — frequently a cry, then a clonic stage with marked cyanosis. The unconsciousness lasts from three to five minutes and the patient then gradually recovers consciousness, is probably confused and bewildered for an hour or so after and then is able to resume his normal daily activities. This treatment is repeated usually every other day for an average of about eight to ten treatments. Improvement is occasionally seen after the first treatment, but generally is apparent somewhere around the fourth to sixth treatment. The patient in most cases is well by the end of the course and can frequently be discharged to his usual activities.

This then is an abbreviated account of shock treatment. The nursing care is as follows:

Pre-treatment: See that the patient has no anticonvulsant sedative, such as phenobarbital, the night before treatment. Make sure he has had no breakfast and that the bladder and rectum are empty. False teeth must be removed and there must be no metal hairpins in the hair.

During treatment: Assist in posturing and holding the patient in the required manner. The chief points for pressure are the shoulders and pelvis; the extremities are gently controlled but not firmly held.

After treatment: Watch the pulse carefully and make sure that an adequate airway is established and maintained. The tongue may fall back and this is especially likely to occur after the use of curare, when the muscles are more than usually relaxed. Most patients lie quietly or fall asleep following treatment. A few are noisy and need physical restraint for a few minutes. In general, the less restraint used the better. The most important thing is to see that the patient does not roll out of bed. Make careful notes of the patient's behaviour and talk during the confused period after treatment. Points of importance in the illness are often revealed then that are not mentioned at other times. Give the patient strong reassurance concerning his recovery from the immediate period of confusion and from the illness for which he is being treated.

If all goes well, the patient almost immediately begins to eat more and to gain weight; then sleep improves, and finally he feels better in every way. It is usually possible for observers to notice improvement before the patient feels it himself. A normal reaction, which frequently alarms the patient and the nurse, is the occurrence of some difficulty in memory during the course of treatment. This is noted in practically every case but need not occasion alarm as there is always complete recovery in two to four weeks after the treatment is completed.

The complications that may occur are as follows: (1) death of the patient — this is extremely rare and occurs in about one in ten thousand cases; (2) the lighting up of a tuberculosis lesion; this is guarded against by the routine chest x-ray made of each patient; (3) traumatic complications such as the fracture of a dorsal vertebra or occasionally a long bone. Vertebral fractures have few clinical symptoms and require no special treatment; we have seen no other traumatic complication. Periods of confusion and memory defect are not serious but may be alarming when they occur in a general hospital because, for a short period of time, the patient is disturbed, does not know where he is and may be noisy and restless. The condition lasts from a few hours to ten days. It always clears up completely but may make management difficult temporarily.

I should like to turn now to the results obtained in the first fifty cases treated by this method. These patients have all been treated in a general hospital or at the outpatient clinic. The re-

sults over a period varying from 3 to 16 months are as follows: recovered and completely well, living at former social and economic status, with neither the patient or his relatives having any complaints — 15 cases or 30%; much improved and able to resume life and work in the community but with some complaints left — 29 cases or 58%; unimproved and still in hospital — 6 cases or 12%. Thus in 50 cases, 44 cases or 88% have either recovered completely or are much improved. The majority of these cases were selected because depression was a prominent part of the sickness. However, these were not cases selected because they were mild but purely with an eye to suitability for treatment. I might emphasize this by saying that seventeen had had periods of hospitalization in a psychiatric hospital; of these, six are now completely recovered, eight are much improved and three are unimproved; of the eight much improved two later relapsed and required hospitalization. In this series of cases five have shown relapses during the period of observation and either been hospitalized or received further treatment. These results are good enough to stand on their own merit in establishing this method of treatment as being worthwhile and very beneficial. It is easier to estimate the value of such treatment in terms of human happiness by the consideration of a few case histories.

Case One: A fifty-five year old man had been depressed for two years, unable to work, crying, sleeping very poorly, believing that he could never be helped and having many delusions of bodily changes. He had gone downhill physically, and his weight had decreased from 175 pounds to 113 pounds. The year previous to treatment had been spent in a mental hospital without any improvement. He was given eight shock treatments with marked improvement after the third treatment. After the fifth treatment his family reported "he was just his old self", better than he had been for many years. He was discharged weighing 132 pounds and at the present time has gained to 165 pounds, feels perfectly well and has carried on his old trade without difficulty.

Case Two: A sixty-three year old woman had been depressed for eight years and been in a mental hospital on several occasions following suicidal attempts. She was very depressed, slept poorly, had lost a great deal of weight and was dissatisfied with everything and everybody. With great difficulty she was persuaded to consent to treatment. After the fourth treatment she showed dramatic improvement, sleeping well and saying she felt fine. She took up all her old activities and, on her discharge following her seventh treatment, was completely well except for some slight memory defect. Seven months later, she is well and active, with no complaints.

Case Three: A thirty-two year old woman was seen during the seventh month of her first pregnancy. She was so depressed that she would make no response to questions, simply reiterating that she wanted to go home, sobbing continuously and threatening to jump out of the window. She was removed from hospital, and kept at home until delivery two months later. At this time she became much worse and was committed to a mental hospital. After a six-months period with no improvement electric shock therapy was instituted. She showed improvement after the second treatment and was discharged within sixteen days. Since that time, seven months ago, she has taken full charge of her house and baby, has no complaints and her husband states that she seems in better health than at any time since her marriage.

In conclusion, I would like to draw one moral from these facts. We have here a method of treatment which will break up many forms of mental disease in a very short time. Many such cases can easily be handled in a general hospital with ordinary facilities; many more could be handled if some slight provision were made for psychiatric cases. It is important that these cases

should be treated in a general hospital because they will be seen and treated much earlier than in a mental hospital, thus cutting down the suffering and financial loss. There is undoubtedly a great deal of stigma attached to hospitalization in a mental hospital. The return to the community is much easier and the chances of subsequent breakdown much less if this stigma does not exist. Such patients deserve the benefit of general hospital treatment.

At present we are able to do a great deal with the hospital facilities which we already have. Unfortunately the expense to the patient is often much more than it should be because of the frequent need for special nurses and the results would be much more satisfactory were special facilities available within the general hospital for such treatment. From the standpoint of an adequate mental hygiene programme it is essential that the general hospitals become interested in psychiatric cases and provide adequate facilities for their treatment.

Electa MacLennan comes to the National Office

Early in the coming year, Electa MacLennan will take up her new duties as a member of the staff at the National Office of the Canadian Nurses Association. Miss MacLennan is now a national office supervisor for the Victorian Order of Nurses for Canada and has been associated with the Order in various capacities for the last six years. At present, her headquarters are in Truro, Nova Scotia, and she therefore has a thorough knowledge of nursing conditions in the Maritime Provinces as well as a good grasp of the general situation throughout the Dominion.

Miss MacLennan was born and educated in Nova Scotia and holds the B.A. degree conferred by Dalhousie University. She is a graduate of the School of Nursing of the Royal Victoria Hospital, Montreal, and in 1933 took the course in teaching in schools of nursing offered by the McGill School for Graduate Nurses. In 1941 she obtained the degree of Master of Arts from Teachers College, Columbia University, rounding out an unusually thorough academic preparation by specializing in supervision in public health nursing. In addition to her broad experience in the public health field, Miss MacLennan also served for two years as clinical instructor and junior administrator in the Vancouver General Hospital.

Miss MacLennan has always been

Photo by Sponagle Studio, Truro

ELECTA MACLENNAN

actively associated with nursing organizations and has frequently held office. Among her various hobbies are stamp collecting, cultivating rock gardens and, whenever possible, choral singing. The National Office is indeed fortunate in securing the services of such a versatile and well-rounded personality.

Hospital Administration in Wartime

EDITH YOUNG

War, with its attendant evils, has made serious inroads into the work of hospitals and schools of nursing. Key people are resigning, their substitutes try hard enough but it takes months to regain the old smooth-running efficiency. Materials and supplies cannot be obtained and there are endless forms to be filled in, and long tedious delays before deliveries can be made. Volunteers become engrossed in war work and tend to give fewer hours of service. Costs are mounting and benefactions are reduced or diverted elsewhere. Much of the joy of administering a hospital or school of nursing seems to have faded. It is at this point we must realize, and assist our communities to realize, that taking care of the sick and injured is war work and results in salvage of life and energy that can be used in the war effort.

Enlistment in the armed forces, industry and marriage have seriously reduced the available number of both professional and non-professional personnel for hospital service. There has been a very rapid turnover in the general nursing staff in many hospitals. Attempts have been made to create interest by means of staff education and consideration has also been given to the reduction of hours of duty. Married and retired nurses have been utilized to a very great extent and hospitals in districts adjacent to military headquarters are in an enviable position since nurses married to members of the military forces are usually willing to work provided some adjustment is made in hours so that they have time to do their housekeeping and are free when their husbands are off duty. Hospitals owe a great debt to these married nurses who have contributed so much but one cannot have the same sense of security since, should there be illness in the family, they naturally feel it their duty to be at home. The community registry has proven an important factor in relieving shortage of nursing staff in hospitals. In some places, if required, private duty nurses each give one month of general duty in the year to hospitals at a rate agreed upon locally.

The conservation of the nurse's time is of the greatest importance and some time-honoured routines could well be dropped such as taking the four-hourly temperature of patients whose temperatures have not varied for a week, and charting the temperature, pulse and respiration on both the nurse's record and the graphic sheet. Routine collections of specimens (sometimes discarded because the laboratory staffs have no time to examine them) should be eliminated. Daily or four-hourly blood pressure records for patients whose charts show an even line from one day to another should be discontinued. Doctors' orders should be reviewed daily to check the

possibility of discontinuing time-consuming treatments without delay.

In some institutions, telephone calls no longer go directly to the floors but are passed to the information desk, thus cutting down all non-essential calls. Elimination of telephone service for patients has been suggested. Every effort should be made to have patients, other than emergency cases, admitted before 4 p.m. Having a definite hour for the discharge of patients has been found advantageous. Friends and relatives should be urged to reduce their visits as much as possible. Other time-saving measures include the following:

Organizing a central dressing room service.

Providing recovery rooms for surgical patients, thus substituting one nurse for the three or four needed when these patients are not segregated.

Purchasing stock solutions of glucose, saline, etc., thus saving the time used in preparing them.

Excusing nurses from accompanying the doctor when he visits patients unless there is some special reason such as a dressing to do. (This is a wartime measure only).

Giving fewer intravenous infusions as a routine. Plenty of fluids by mouth and otherwise have been found just as effective in certain cases.

Much time is saved when the instructor of nurses is familiar with material covered in other courses than her own and it has been proven a highly profitable policy for instructors to visit each other's classes, particularly where similar content might be included. Improvement in the arrangements for affiliated students and more careful grouping of classes has eliminated unnecessary repetition. In some institutions, where such courses are available, nurses with an aptitude for surgery are offered postgraduate courses in the operating room and are paid general duty rates during that time; this policy applies to other special departments as well. Bursaries to enable the graduate nurse to take one of the special accelerated courses offered by universities to fit her for advancement to greater responsibility as clinical ward teacher, supervisor or head nurse, has helped to provide personnel for these positions.

The chief problem related to student nurses is that of insufficient applicants with suitable qualifications. The recent intensive publicity campaign has produced an increase in enrolment in large hospitals, despite the attractions and salaries in other war services, but the problem in medium and smaller hospitals has not been solved. The suggestion that a clearing bureau in each province might be established, so that applicants who cannot be accommodated in one school might be referred to others, is worthy of consideration. This is not the time to ask a good applicant to wait for a later class if some other school can prepare her for the nation's needs. On the other hand, the student must be assured that we are teaching her to nurse and not using her to fill domestic shortages. This implies the provision of full-time instructors and one or more clinical supervisors according to the size of the group.

The shortage of domestic help might be illustrated by the story of the employee who dropped a diet tray within the administrator's hearing. Another employee, knowing the administrative difficulties, remarked, "More trouble for you, Miss Jones", to which Miss Jones replied, "That's not trouble, that's the best news I've had today. It proves we still have at least one employee left on duty". The shortage and rapid turnover appears critical and has made it necessary to employ every one who asks for work (including older men and women), the part-time employment of married women, and of ex-patients from sanatoria.

Would not some foresight in recog-

nizing the superior worker and in having some pension scheme for security prevent a repetition of the present critical situation with regard to domestic workers? Keeping employees informed of the broader aspects of the hospital's problems has also produced more interested and sympathetic attitudes among its personnel. The social prestige of the job is often more important to the employee than money and a desired transference to another department, or promotion through merit, gives them pride in their work. Titles, and appropriate uniforms, have helped to retain valuable members of the staff. Salary increment, based on merit and tenure, and cash bonuses for definite periods of satisfactory service have tended towards stability. Giving a cash salary and having those residing at the hospital reimburse the institution for the value of their room, board and laundry, has given employees a sense of the value of maintenance.

To promote stability in both professional and lay staffs, interest is being aroused in many ways such as suggestion boxes for the improvement of working conditions, questionnaires to various departments and more frequent departmental conferences. Improvement of living conditions plays a vital part in the satisfaction of the resident staff. Dining rooms that are sound-proofed, with attractively decorated walls and gay new linens for the tables, have paid dividends in soothing frayed and jangled nerves. If cafeteria service has been established, there should be an experienced manager to see that the food service is attractive and that it maintains standards of prompt and courteous treatment.

Many types of personnel may be used as paid ward aides. Giving them ing rooms and a table in the nurses' such privileges as separate rest and dress-dining room has meant that some hospitals have been able to maintain a satisfactory and stable group. The provision of a special uniform with or without caps has also been beneficial.

Unpaid volunteer nursing auxiliaries, drawn from the ranks of the Red Cross Society, the St. John Ambulance and other service groups, may satisfactorily carry on non-technical duties related to the care of the patient. They have also given good service as receptionists and typists, and in the housekeeping and dietary departments. Business girls, teachers and students have given valuable help on Saturday afternoons and Sundays. These volunteers must be assured of the need of, and gratitude for, their services and the regular nursing personnel, student and graduate, must be taught to appreciate the assistance given by them and not to take advantage of it by soldiering on the job and letting the voluntary helper do the work.

Because they help to save time and energy, a few practical suggestions concerning the conservation of supplies and the maintenance of equipment are also worthy of consideration. A frequent survey of the physical facilities should be made and when there is evidence of need of repairs they should be made immediately in order to minimize the amount of destruction and injury. A survey of electric lighting facilities might indicate the use of smaller bulbs. Complete instructions should be given regarding the use of complex equipment such as sterilizers. Old printed forms may be cut into sizes suitable for memoranda or for reprinting small forms. Smaller sized envelopes and writing paper may be used and pencils, already sharpened down to three or four inches, can be sharpened once more. The same kind of antiseptic should, as far as possible, be used for skin preparations or other routine procedures and solutions should be sprayed on the skin with an atomizer rather than applied with gauze. Small dressings should be utilized when possible and the use of smaller abdominal dressings also cuts down the consumption of adhesive.

Strips of muslin can be used to tie an arm to an arm board while giving intravenous treatments, thus saving gauze bandages. Prompt repair of surgical tools and replating of instruments prolongs their life considerably. Scalpel blades may be sharpened four or five times and used for certain surgical procedures both in the operating room and on the wards. The use of needle sharpeners has reduced the quota of needles required. Conservation of linen may be effected by careful and immediate washing out of stains. Attention should be given to the prevention of over-sterilization of linen used in surgery and to avoiding the injudicious use of towel clips which make sizable holes in drapes when these are carelessly removed after operation.

Substitution of various articles makes for economy. Cookie tins may be used as surgical trays and kitchen enamelware for surgical bowls. Wrapping or parchment paper makes good covers for sterile trays. Clothespins may be used instead of forceps to fix sheets to anesthetic shields and to fasten drapes around solution bottles. Plumber's waste has been found useful for involuntary pads.

Despite the difficulties that arise from day to day in our hospitals and schools of nursing, leadership and a high degree of morale will do much to maintain hospital service at a high level. Nurses serving in the hospitals on the home front need just as much encouragement and praise as nurses serving with the armed forces. Perhaps more, for their job has all the nerve-racking elements common to both, without glamour. We must give hospital nurses more credit than ever before for their efficiency, patriotism and co-operation in the war effort.

Beatrice Ellis—an Appreciation

In July 1904, there arrived at the Toronto General Hospital a young woman of dignity and charm whose personality won for her a special place among her classmates. With the background provided by teaching in rural New Brunswick, her enquiring mind, coupled with a deep interest in the welfare of patients, laid the foundation for professional attainment in the years to come. Beatrice Ellis was graduated in 1907 under the superintendency of Mary Agnes Snively, and for the following five years was assistant to Miss Snively and to her successor, Miss Robina Stewart. Subsequently she enjoyed a few years of private duty nursing and earned for herself this tribute from a prominent physician: "Miss Ellis was one of the finest nurses I have known".

Photo by Freeland, Toronto

BEATRICE ELLIS

In 1915, the Toronto Western Hospital appointed her as its superintendent of nurses. Five difficult years of wartime, followed by the influenza epidemic, demanded a change so she returned to private duty, but in 1923 the Board of Governors again prevailed upon her to accept the position of Director of Nursing and Principal of the School of the Toronto Western Hospital.

Year after year a succession of advances and reforms were brought about. With a constant devotion to the development of the School as an educational institution, Miss Ellis secured registration for it in the State of New York, and has maintained this relationship throughout the years. Affiliations were arranged with the municipal Department of Health — the Toronto Western Hospital being the first school in Toronto to establish them. Then the course of instruction was broadened to include experience in pediatrics at the Hospital for Sick Children, in communicable diseases at the Riverdale Isolation Hospital and at the Toronto Hospital at Weston. With the expansion of hospital facilities the School, whose enrolment in 1915 numbered 60, grew to 200 in 1943.

The responsibility for any measure of success which the graduates of this School may have attained has been the inculcation of Miss Ellis's maxim: "trifles make perfection but perfection is no trifle". This caption appears on the black-board when, at the close of their preliminary period of training, the students of the class are examined on some aspect of nursing by Miss Ellis herself. From the time of her acceptance into the School, each student is interviewed on the first day of the month by a busy executive officer who nevertheless takes time to guide the development of her students. Later in the course of lectures on professional adjustments, a precious opportunity is provided for discussion and debate between untried fledgelings and their intellectual leader. During this course, her enthusiasm stirs the mind to read and to enquire and we learn to know and love "our Miss Ellis".

While few of her assistants could measure up to her high ideals of service, we have always felt free to seek her advice. Her penetrating and discerning analysis of a paper or a report is followed by constructive criticism and encouraging comments. All matters pertaining to nursing organization claimed her attention. In 1919 she was appointed secretary of the Graduate Nurses Association of Ontario and, reappointed in 1922, remained in office until 1926 when the G.N.A.O. became the R.N.A.O. The formation of the committee on instruction in Canada resulted from her suggestion that instructors should have a common meeting place for the discussion of their problems. At the present time, Miss Ellis is convener of the Ontario Committee on Emergency Nursing.

"Why waken patients so early" was the arresting title of an article, written by Miss Ellis, which appeared in *The Canadian Nurse* several years ago. Today, the students at the Toronto Western Hospital would tell you gratefully that she has answered that question to the satisfaction of both patients and nurses for, since last March, they have been given an extra half-hour in bed, reporting on duty at 7.30 a.m.

We are fortunate in having our teacher and friend remain in Toronto and shall look forward to many years of counsel from her. Freed from the pressure of active work, Miss Ellis hopes "to enjoy all the things I haven't had time for". So to this leader in the nursing world of Canada we do honour.

—GLADYS SHARPE

HOSPITALS & SCHOOLS *of* NURSING

Contributed by the Hospital and School of Nursing Section of the C. N. A.

Making a Comeback

MRS. J. A. RUSSELL

I am one of many married nurses who have re-entered the nursing world during the last few years. We have come back into various branches of the work; some to administrative work, teaching, industrial nursing, public health, private duty, and some to general duty. I am at present engaged in general duty, and I think all of us who have made a comeback have been motivated by the great need for nurses and by the desire to be of service. With what trepidation I began my first day's work! But when I found, after spending my first four hours on the ward, that faces were still washed in the same manner, bed baths given in the same way, and in fact all the basic bedside care had remained constant, I began to lose my jittery feelings and to recover some of my former confidence. I have since concluded that the patients even have the same old complaints I used to hear when I was in training.

I feel that it is bracing to escape from the housekeeping and homemaking grooves into which I had settled and, while there are two definite adjustments to be made each day—that of becoming professionally-minded, and then, on return to the family, domestically-minded —yet these are made more or less unconsciously. It seems to me that the two most important factors which enter into the success of the adjustment are first, suitable arrangements for the care of the child remaining at home and second, sympathetic understanding on the part of the institution in which one works. The mind must be easy, and free of worry over the family, both for our own sakes and for the sake of the service we hope to give. The second is equally important, and those concerned with the arrangement of hours have been most considerate. Just here, may I mention that I feel we of the general duty staff should be as co-operative as possible and not allow trivial matters to interfere with our decision as to just which hours we shall work. Let us put first, our responsibilities to our families —then our responsibility to our professional work. If we do this, any consideration we may request will be likely to be treated as legitimate. The sacrifice of a few social activities in days such as these must not weigh too heavily with us.

There are always advantages and disadvantages in all enterprises, and those who do general duty in any institution find this to be true of their particular enterprise. The part-time nurse must feel at a disadvantage because she arrives after the nurses' day has begun;

either an hour or so after, or several hours after, as the case may be. The various patients have been discussed when the night report was given and definite plans have been made for the day. All the nurses have dispersed and each is engaged in her own work, yet having a general knowledge of the whole ward. Into this environment steps the part-time nurse, finding it difficult to know where she belongs. If the institution employs the case assignment method, then indeed she is fortunate, for she will have certain patients assigned to her and will be responsible for their treatments as well as for their bedside care. But if, on the other hand, the efficiency method is carried out, the part-time nurse has small opportunity for practice in anything but routine bedside care. She has little or no chance to brush up on treatments, long since become rusty, or to see given, and learn to give, new treatments and medicines. This tends to exaggerate that alien feeling, and to set her apart, as it were, from the nurses on the regular staff. When we can be general duty nurses in the full sense of the term, then we feel we are being used as graduate nurses and are being given an opportunity to broaden our knowledge, and improve our nursing.

As we step back from the ward into our homes, we are bound to meet with other disadvantages which are, more or less, a direct outcome of our absence. These confront us with the opening of the front door—unmade beds, unwashed dishes, unironed clothes—in short, unkept house. Thus, instead of having an afternoon free, I almost always have one full of housework of varying kinds, which very often extends far into the evening. Thus social activities must be forfeited if I am to do my bit, and keep my household from suffering. I venture to say this may be true of most of us.

We may be inclined, at times, to feel that the disadvantages outweight the advantages, and be tempted to give up this dual role. But somehow the advantages have a way of re-asserting themselves, and the inconveniences shrink into the background. The contact with the members of the nursing staff, and indeed with many of the patients, is well worth the foregoing of many social activities. The remuneration must not altogether be overlooked, while we are speaking of advantages, for in these days of high prices and many calls incident to the war, there are few who do not welcome an addition to the regular income.

The absence of the mother from the child, for a few hours each day, seems to bring out the child's sense of responsibility and we find him trying to do little things to help and thinking a bit more for himself. Last, but most of important of all, the satisfaction derived from the privilege of helping far outweighs all the minor disadvantages. And so we find ourselves adjusting to the dual role of nurse in the hospital and mother in the home. Most of us, I can safely say, are enjoying it immensely.

Obituaries

Arlene Vivian Lyford was accidentally drowned this summer while swimming. Miss Lyford graduated in 1935 from the Montreal General Hospital School for Nurses, and later joined the nursing staff of the Verdun Protestant Hospital. A capable and conscientious nurse, she was a valued member of the staff of that institution.

Helen Winnifred Spier died recently at the Montreal General Hospital. Miss Spier was educated at Trafalgar School and King's Hall, Compton, and graduated from the Montreal General Hospital School for Nurses in 1930. She was engaged in private duty nursing for several years. Her sudden death was a great shock to her many friends.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association.

Planning Field Experience for a Postgraduate Course in Public Health Nursing

GERALDINE LANGTON *and* ISABELLE CHODAT

Every Canadian university offering courses in public health nursing has, within the past year, been confronted with an enrollment of postgraduate students of markedly increased proportions, and the University of British Columbia has not been an exception to this. Promoters in the public health field are enthusiastic about the prospects of such a situation, for they hopefully look forward to a time when they may draw upon a large body of trained personnel to meet the needs of rapidly developing fields in public health.

What has brought about the condition of an increased number of nurses showing sudden interest in public health? It is felt that publicity in this field is gradually bearing fruit. Nurses are now financially, through steady and better employment, in a position to fulfil their desire for postgraduate study; and again, governmental grants to students, and to universities and public and private agencies offering opportunities in student education, enable them to enrol or to offer enrollment in public health nursing courses.

It is the aim of this article to give some account of the methods used by the University of British Columbia in meeting this situation of increased enrollment, with particular reference to the field practice periods. During the 1942-1943 session, this University was in a position to withdraw to some extent its restrictions to a limited enrollment; in the same year the number of registrants increased almost 50% over any previous year. How was the course to be organized to meet the needs of this larger body of nurses? The theory or lecture courses could be accommodated with a fair amount of ease, some lecturers being called upon to repeat certain courses. However, providing suitable field work experience produced problems more difficult to solve. The health and social agencies, used as practice centres in the past, now had major case load and staff problems of their own which curtailed their ability to supply a suitable type of field experience. Despite their willingness to share in this responsibility, they could not handle the extra large group of nurses requiring field work but preferred to take less than customary. A means of overcoming these difficulties was seen in the appointment, through the government

grant, of field work supervisors in two of the large experience centres — the Victorian Order of Nurses and the Metropolitan Health Committee.

In order to understand the plan which was to be developed through these new appointees, a brief review will be given of the arrangements as carried out in the past. The University of British Columbia adopted a programme providing the postgraduate student with three weeks each of urban and rural practice, with shorter periods spent with some or all of the following agencies, depending upon the student's background of experience: social agencies; government divisions for the control of venereal disease and tuberculosis; mental institutions and psychiatric clinics; industrial nursing; nursing schools and kindergarten. It was customary to spend four weeks with the Victorian Order of Nurses. Each experience was co-ordinated one with the other and with the lecture courses through the University field work supervisor.

The general plan for the last University session followed the trend of providing longer field work periods with one or two agencies, rather than shorter periods with a number of agencies. One basic period of five weeks was to be spent with a generalized public health nursing agency which could offer facilities for close supervision of the students. Other periods of field work were based upon the nurse's previous experience, either as an undergraduate or in postgraduate work. If a nurse showed a rich background of experience she was offered an elective, otherwise with nurses not so fortunate, every effort was made to bridge across the fundamentals found lacking.

The agency chosen for the basic period was the Metropolitan Health Committee. Here a large variety of services could be demonstrated, and the University could call upon the assistance of the full-time student advisor who, as previously mentioned, was recently appointed by this agency. There was a splendid opportunity to offer these public health nursing students independent participation under supervision. In order to give the nurses an opportunity to carry family assignments with a view to long-term planning, the five weeks were broken into half-week periods extended over a total period of nine weeks. The first half of the broken week the students attended University lectures.

In order to derive the greatest value from the basic period a good deal of effort was made to integrate this experience by contacting and working with other related community services, whether public health or social. To do this public health and social workers attended and contributed actively in individual or general conferences with the postgraduate nurses. Hence this experience embodied in it the idea that public health nursing is part of a broad community service, and was designed to promote the orientation of the nurse into public health in general. Vision in the field of public health and general basic principles were emphasized, rather than the narrower interpretation of policies and procedures for any one agency.

Once the general planning was done, and the agencies concerned were aware of their respective roles, there remained the very essential task of specific planning. This was carried out jointly by the field supervisor from the University and the student advisor of the Metropolitan Health Service, the one contributing more in relation to principles of learning, general methods, etc., the other more in relation to the technical aspects involved in the planning of time-tables.

A basic plan was outlined which included experience in every phase of the service rendered by the Metropolitan Health Committee. As this service does not have a completely generalized programme, the facilities of other agencies

were used. The individual time-table of each nurse was based on this plan, changes being made according to differences in districts and time-tables of staff nurses. The basic plan included: (a) five introductory conferences; (b) ten half-days in elementary school; (c) one half-day in high school; (d) four afternoons in a child health centre; (e) eight conferences about families on which both a student and a social worker were to be active; (f) one group excursion; (g) one general staff meeting; (h) one half-day in the unit office; (i) approximately four half-days for preparation of district visits; (j) approximately fifteen half-days for visiting in the district, making contacts with other workers, and recording.

Before individual time-tables were planned in detail, consideration was given to the assignment of students to staff nurses. The students' experience sheets were reviewed, and any pertinent facts such as length and type of experience were noted. Each one was assigned to that staff nurse who, by virtue of her own professional and personal qualifications, seemed best able to provide adequate field experience. It was also necessary, at this stage, to consider the responsibilities of all those persons in the agency who would be having contact with the students; that is, the field supervisor from the University, and the student advisor, generalized supervisor, and staff nurse from the organisation. The staff nurses were already carrying heavy case loads, and would not be able to devote sufficient time to the teaching and supervision of students. It was arranged, therefore, that the staff nurse would be responsible for the student's experience in the school, the unit supervisor in the child health centre, and the field supervisor and student advisor in the home.

Finally, individual time-tables were compiled. In arranging the items previously mentioned, provision was made for observation, then participation, then evaluation of the student, with continuous supervision throughout. When this was completed, a meeting was held in which staff nurses, supervisors, student advisor, and field supervisor were present. The complete map of student experience was discussed. Objectives were reviewed, responsibilities were outlined, and technical points clarified. At the same time, the students were prepared, in a conference with the field supervisor, to recognize their responsibilities to the agency. They were given an understanding of the way in which their field experience had been planned and an idea of what was expected of them. All was in readiness, then, for putting the programme into operation.

A special room in the headquarters of the agency was set aside for teaching purposes, group conferences, and demonstrations, individual conferences with supervisors, and study. This was called the "student room". A small library with the best books and articles available was set up here, complementing the library at the University. Equipment consisted of three large tables, chairs, cupboard, blackboard, desk, bulletin board, and an extra small table.

As this basic field experience was provided with the object of preparing students to work in any area, with any type of public health nursing organization, it was realized that care must be taken to consider, at all times, the principles, objectives and trends as related to the many aspects of public health nursing service, rather than the policies and methods of this particular agency. For this reason, five introductory conferences were held in the student room. In these conferences, the following material was presented:

General Introduction: This included a brief description of trends in nursing education, the set-up of the Metropolitan Health Committee, and the planning of the student programme.

Introduction to Family Health Service: The objectives of family health service had already been studied at the University. Therefore, the emphasis was placed on describing the family set-up and its place in the community, the medical, behaviour, social and economic aspects of family health, collecting and analyzing data on the family, plans for teaching in the family, and the compilation and use of the case record.

Introduction to Child Health Service: Here again the objectives of such service had already been reviewed for the students, so that it seemed of more value to discuss such matters as the scope of a child health service, the indications of the need for such a service, the essentials of a child health centre, with special reference to the parent-nurse conference, the physical set-up and organization of a centre, and the home visit.

Introduction to School Health Service: An effort was made in this conference to bring about an understanding of the administration of a school health programme, its purposes, the respective responsibilities of the health department and board of education, and the opportunities for cooperative participation on the part of both.

Introduction to Communicable Disease Service: The requirements of the public health nurse for rendering such a service were reviewed, following which each phase of the service (environmental sanitation, reporting, isolations and quarantine, medical and nursing care, immunization, research, and education of the public) was discussed. A member of the Provincial Board of Health Laboratory staff spoke to the group about the services of the laboratory and the need for understanding and co-operative working relationships between the public health nurse and the laboratory personnel.

The conferences were conducted in lecture form, followed by free and spontaneous questioning and discussion. A real effort was made to follow them up, as soon as possible, with a practical application of what was learned in the classroom, but because of the large number of students, this was not always possible. However, at the beginning of their field work experience, all nurses were given four families to carry for complete family health service. These families were selected by the staff nurses with a view to providing a variety of health situations and possibilities for accomplishment. The staff nurse supplied the basic information for the student. Then, before visiting, the students compiled their records on the families, made their plans for visiting, discussed their cases with the field supervisor or student advisor, built up their background of knowledge through reading, and outlined their teaching units briefly, according to subject matter, on index cards.

Each student had had the opportunity of observing visits of the staff nurse to whom she was assigned. She had been introduced to her families by the staff nurse. After she had made one or two visits on her own, she was supervised by either the student advisor or field supervisor. Then she carried along on her own for the remainder of the field work period, seeking assistance as she required it. During the last week, she was supervized again, and her progress noted.

Each student carried one additional family in which a social worker was also active. These families were referred by the social or medical-social agencies (Children's Aid Society, Family Welfare Bureau, Hospital Out-patient Department, Division of Venereal Disease Control) for the health problems which they presented. In referring these cases, the social worker from each agency met with all the nurses. She described the functions of the agency, and presented the cases to all the students. Together,

the students discussed the cases and made plans for giving services concerning the health problems. Then each case was turned over to the particular student who would be visiting, and she carried the case co-operatively with the social worker concerned. At the end of the field work period, another conference was held to discuss the progress made and the part played by the social worker and public health nurse respectively.

In the child health centre, the student observed for one session, then had a detailed demonstration from the generalized supervisor of the various activities of the nurse in a child health centre. At the third session, the student admitted and had conferences with mothers on her own. On the fourth afternoon, she returned the demonstration to the supervisor. In school, the staff nurse encouraged the student to work right along with her and, as the student seemed able, she was allowed to take more and more responsibility. Certain routines were demonstrated and the student was asked to return these demonstrations. However, in all the activities of the nurse, a description of purpose and procedure was given. The nurse based her evaluation on definite criteria which had been drawn up before the students were received into the agency.

One would wonder how a constructive evaluation could be given with supervision coming from so many sources. To provide some common basis for evaluation, guides were drawn up for the use of staff nurses and generalized supervisors. These guides were patterned on the evaluation form used by the University, but were changed to apply specifically to school and child welfare service. The student advisor and field supervisor used the University form without change. Evaluation took place continuously and, on completion of the field work experience, a joint conference of field supervisor, student advisor, generalized supervisor, and staff nurse, was held to discuss each student, and the final evaluation made out. This was found to be most successful, as it was the product of the observations of four persons and therefore tended to eliminate bias and subjectivity.

An effort was made, throughout the entire experience, to encourage the students to evaluate themselves. On their last morning with the agency, the students were asked to evaluate themselves, using the same form as that mentioned above. These self-evaluations were helpful inasmuch as they revealed the student's own awareness of her strengths and weaknesses. Evaluations were reviewed with each student by the field supervisor or student advisor, specific instances being given for every constructive criticism made. Strengths as well as weaknesses were revealed, and guidance given to the student concerning job possibilities for the future.

Conclusion: How did this basic period method measure up? To arrive at some definite conclusions a meeting was held with the student body, together with representatives from other interested agencies, the student advisor of the Metropolitan Health Committee, and the University field work supervisor. A summary of these findings is as follows:

1. The basic period of integrated activities proved a highly valuable and interesting experience.

2. Much was gained through group demonstrations and group discussions concerning general public health principles and case studies.

3. The opportunity for independent participation over a period of several weeks, with the help of direct and indirect supervision, did much to encourage each public health nursing student to think problems through and to take action.

4. The family assignments gave each

nurse a live opportunity for record-writing.

5. The student nurses learned to look upon supervision as a means of constructive guidance and as an integral part of every planned programme.

6. Evaluation, being continuous, gave opportunity for development of each student, and the final evaluation, being a composite report made up by several workers, tended to eliminate subjectivity.

Blue Serge Ladies

It is a most successful operation. That is it will be if the Nurse survives. She hasn't many days of her years. She has just left her hospital training school behind her. She cannot have much experience. This is not said in criticism. It is said in profound admiration of one of our younger generation who is tackling a big job, no less than that of medical and nursing adviser for a municipality.

The Department of Public Health would have preferred a nurse with experience, but those sort are not to be had. They would have preferred a doctor, municipal or otherwise, but these are not to be had. The girl in the blue serge, with the temperamental grey car, and the leather case is the answer.

Cartier municipality has provided a centre for her, perhaps with the vague idea that sometimes she would be in residence. She is, when she is not called out. There are scales there for babies and for adults, a cupboard with nursing supplies which may be loaned out, even including sheets and towels. There are shelves of drugs and rolls of absorbent cotton. There is even a long table with its padded cover, though we do not think that "Nurse" undertakes operations, not major ones anyway. That office is a combination of nursing station, pharmacy, and doctor's office. And just one girl in charge.

The Public Health Department is not pretending that this is an ideal set up. It is an emergency stop gap, with a young blue serge lady holding the line.

These nurses have municipal committees to help them, and sometimes they do. They hold well baby clinics once a month where the mothers can bring their pre-school fry. They hold clinics for immunization inoculations, against smallpox, diphtheria, and whooping cough. Our "Nurse" had had a hundred small folks at the one organized there and there would be others. Our "Nurse" also is going to have a dental clinic when the harvest is in. She has a hundred dollars put by for it. That money was secured by community endeavor by the corn roast route. Another community had raised the money for the sick loan cupboard equipment, and still another had presented the centre with six layettes.

The nurse in these municipalities has the schools under her care. There are twenty-two of them in Cartier. She visits them and examines the children for a long list of things which small flesh is heir to. Defective vision, for instance. Already four children in Cartier have been fitted with glasses, three sets of which were paid for by the parents concerned, and the fourth was secured by the efforts of the neighbors — raffling a pair of pillow cases, if you must know.

The Nurse has charge of the T. B. cases in the municipality, the list being furnished her from the department. She

follows up cases, looks after contacts even after the patient has been taken to the sanatorium, and generally teaches health in the stricken home. Indeed she is at that all the time, not only in the more or less formal classes at the centre and in the schools, but on each visit and indeed at every meeting. She is also a whole battalion in the venereal disease campaign.

We were only with her for a few hours, so haven't yet penetrated the mystery of when she gets a complete meal, or any sleep. At luncheon we had only got to the dessert although we will admit the fried chicken course was only a delightful memory when she was sent for. A man had caught his finger in the threshing machine with not too good results. At supper she couldn't have got more than one bite and a gulp of tea, when she was called to a youngster some miles away who had "an awful pain". For the first call, away from the Centre, a two-dollar fee is charged. The follow-up is free. Just how this call turned out we cannot say for the last we saw was the grey car getting under way.

"I do not know how we managed before she came", asserted a resident to us. Well, we don't know either.

—KENNETHE M. HAIG
in the Winnipeg Free Press

A Problem in Rehabilitation

HELEN LARKIN

The Samaritan Club of Toronto has as its aim the prevention of tuberculosis and the giving of practical assistance to the needy who have been in contact with the disease. A survey was recently undertaken under the auspices of the Club because it had been noted that, in the central part of the city, almost one-third of the referrals had been single or unattached men. It was suggested that the findings be interpreted from the point of view of their interest to nurses and this is herewith attempted.

During a three-year period 190 single or unattached men have been referred. "Unattached" has meant that a man was separated from his family. Some had left their homes during the depression years because of the unhappy situation created when they had been unable to support their families. Others had found, on their discharge from sanatorium, that their wives, partly because of their fear of tuberculosis, had been unwilling to re-establish a home. Referrals come to us usually from one of three sources: the medical officer of health, the public health nurse and, less frequently, from the patient himself.

Prior to their illness the majority of these men lived in rooms, many of them in hostels. Since July 1938, when the Sanatoria for Consumptives Act was revised, the municipalities in Ontario have been responsible for the care of needy patients ready for discharge. In Toronto they have been placed in boarding homes, known as tuberculosis after-care homes, which are supervised by public health nurses. Usually we have our first direct contact with these men following their placement in one of these homes.

Of the 190 patients observed, 93 were Canadians and 23 came from other parts of the British Empire. The remaining 74 came from 18 different countries, 19 of them from China. The variety in racial background appears to be indicative of the known fact, which so many people, descendants of early

settlers, refuse to accept, namely that Canadians are now a people of many racial backgrounds. The age groups at time of admission to Sanatorium were as follows :

10 to 20 years: 12; 20 to 30 years: 45; 30 to 40 years: 40; 40 to 50 years: 39; 50 to 60 years: 25; 60 to 70 years: 11; over 70 years: 1; unknown: 17.

Having heard so much of the dangerous 'teens and twenties, it was surprising to note the ages of admission to Sanatorium of this group, and especially the almost equal numbers in the decades 20 to 50. The National Tuberculosis Association 1939 pamphlet states that the largest toll in women is from 15 to 29, and in men from 45 to 59, thirty years later than in women. From a preventive and teaching point of view, this would seem to be a fact that the nurse should bear in mind. One would expect that people who had been contacts would also wish to be made aware of it.

Occupations prior to admission to Sanatorium were as follows : semi-skilled trades: 26; labourers: 25; restaurant workers: 18; odd jobs: 14; drivers and motormen: 9; white collar jobs: 9; factory workers: 7; sailors: 5; farmers: 4; barbers: 4; school: 3; miner: 1; unknown: 65. It has been stated authoritatively that, although a few occupations are hazardous for tuberculosis, it is the wage level and the standard of living which it makes possible which is the chief influence; also that there are eight times as many deaths among unskilled workers as among professional men. As to the wage level, we did not have complete statistics regarding employment but 57 of these men had been unemployed prior to their illness. One cannot help but feel that the battering about, the irregular and uncertain meals, the inadequate clothing, and the over-crowded and uncertain living quarters of the depression years were directly responsible for the illness of many of them. As to occupational influence, our figures seem to bear out the fact that the majority lacked special training for their jobs.

The statistics regarding return to sanatorium seem discouraging from the point of view of the patient, and also from that of the taxpayer. They only bear out other statistics as to relapse. The point that really stands out is the urgency for early diagnosis and treatment and that the earlier the diagnosis the better the prognosis.

Nurses know that there are three general types of diagnosis in pulmonary tuberculosis, namely minimal, moderately advanced, and far advanced. Do they know that in minimal tuberculosis there is an excellent chance of almost complete recovery; in moderately advanced less so, and in far advanced still less chance of return to good health? Minimal cases often show no symptoms whatever but an x-ray will reveal the trouble; this type of case may need treatment for a few months only.

Everyone should know that there are simple and inexpensive ways to test for tuberculosis. The method with which we are familiar is the I. C. test which indicates reactors, who are then x-rayed. Portable equipment and the 35 m.m. miniature and quite inexpensive film may be used. If trouble is indicated a larger x-ray is taken.

All ex-patients resent the attitude of fear towards themselves but they are helpless to do much about it. Most of them are punctilious about staying out of homes where there are children. They excuse the attitude of the public only because they know that prior to their admission to sanatorium they had been equally ignorant. In order to change this attitude, could not the nurse stress the following facts: first, that all adults should avoid prolonged and intimate contact with the grossly careless tuberculous person but there is little to be feared through ordinary contact;

second, that most adults have been exposed to infection in childhood in small doses and an immunity has been developed. An adult should be taught to build up his defence against the germs already in him, to avoid other diseases, overwork, under-feeding, poor housing and dissipation. He should be taught to seek rest, sleep, good food, fresh air and moderate, temperate, healthful living. The nurse could also explain that while in sanatorium the patient receives an education in healthful living. They are told that for the first few years after discharge they may work or play, but they cannot do both and that they should seek light, sheltered indoor employment. They know that their condition is arrested but not cured. A surprising lack of understanding has been noted where one would least expect it. For example, the case of a young expatient who worked in a store without rest periods and who was asked to stand all day. Of course, this young man had to return to sanatorium. Now he is extremely bitter about his breakdown which he attributes to the thoughtlessness or selfishness of his employer, and this time he refuses to study or think of preparing himself for life outside. We have known a number of men who were so irritated because they were considered lazy or shiftless that they have undertaken work beyond their strength and before long have had a relapse. Some men have been so conscious of the ostracism of the community that they have been relieved to return to the sanatorium.

It is recognized that the man who has done a heavy unskilled job cannot return to this type of work and the necessity for specialized training is an unquestionable need. As well as regaining his physical health, the man of this type has the additional handicap of having to acquire a new occupation if he is to be self-supporting again. Many of these men, however, have spent their time in sanatorium without making any preparation mentally for their return to the community. We have noted two distinct types of reaction—one where the man has dropped into an apathetic state—the other (and this has been learned only when one has come to know the client quite well) where he is desperately turning over and over in his mind ways and means by which he may become self-supporting.

One plan which is being worked out successfully in the United States is that rehabilitation shall commence soon after the patient is admitted to sanatorium unless he is hopelessly ill. His occupational background is discussed, aptitude tests are given and plans for study made. Only this week a client in one of our tuberculosis after-care homes, having heard of the aptitude tests for vocational training given in our army, asked if such a test could be arranged for him. Anyone who has had much to do with ex-sanatorium patients will know how much time is spent by these patients sitting about with nothing to do, no money to spend, few friends, little church or social life. It seems to be a matter of decency to human beings to do something about it.

In closing, may I suggest that the nurse take advantage of the present day trend to work with volunteers. I would like to refer to our own organization. Apart from our executive secretary, three case workers and an office secretary, the club is made up entirely of volunteers. There is a senior board of 60 members who direct all matters of policy; added to their administrative functions, the Board makes possible special nourishment in the form of milk tickets and grocery vouchers to be sent wherever needed. We also supply many patients with vitamin preparations which are lacking in the diet of the average Canadian. There is the junior branch of the Samaritan Club with 90 members who are mostly young married women,

and who have done outstanding educational work. This year they are in the advance guard, having recently arranged that every member and her children shall have the I. C. test and, if necessary, further examination and treatment. The city is divided into twenty-four districts, each with a district leader whose duty it is to collect an annual fee of one dollar and there is a city membership of over 1,200. These outside members have little to do with the actual work of the club but their interest is aroused through an occasional district meeting and through the annual report which they receive by mail. With an active committee to lead and to arouse public interest, this method for raising funds could be used in almost any community. Prevention and rehabilitation work could go hand in hand and the attitude of "I hope I never have anything to do with tuberculosis" could be changed to "Tuberculosis is preventable. Let's face the facts and find out how it can be done".

Making the Front Page

Once upon a time the fat and prosperous journals, published by various hospital groups, were inclined to relegate nursing service to the back pages, neatly sandwiched in between advertisements of laundry machinery and battleship linoleum. Those were the days when nurses seldom if ever "made the front page". Perhaps because blessings seem to brighten as they take their flight, nurses now seem to be coming into their own and, in the September issue of *The Modern Hospital*, there is a portfolio of no less than twenty-six pages, devoted almost exclusively to nursing service and nursing education.

This portfolio contains some very plain talk, much of it from nurses themselves, and deals with conditions of employment that have made it difficult for hospitals to attract and to retain the services of a stable and competent nursing staff. Another article, written by the president of a college for women, tells us (as we already know from sad experience) that student nurses who have completed high school are sometimes "unable to write a complete sentence, can't multiply or divide, and don't understand decimals either". Well, here is *one* problem that neither hospitals nor schools of nursing can reasonably be expected to solve but are justified in politely handing back to the teaching profession for appropriate action. Judiciously mingled with these salutary if critical findings, are some thoroughly constructive statements bearing on such subjects as the use and direction of the Cadet Nurse Corps.

This portfolio renders a real service to hospital administrators and to nurses because it honestly tries to get at the root of the matter and gives positive proof that hospital administrators in high places are no longer taking nursing service for granted but are beginning to understand the importance of fostering and conserving it. One good turn deserves another and, although we can't promise anything so ambitious as this portfolio, an early issue of the *The Canadian Nurse* will offer a modest tribute to hospital administrators (and editors of hospital journals) who try to give nursing service a fair deal.

Notes from the National Office

Contributed by KATHLEEN W. ELLIS

General Secretary and National Adviser, The Canadian Nurses Association.

Over a period of years nurses throughout Canada have looked forward to *Notes from National Office* to bring themselves up to date with the latest professional developments. Many a subscriber has looked backwards too and refreshed her memory from this source of official and valuable information which has been supplied regularly by the Executive Secretary. Now, after years of service, the significance of which cannot be recorded in mere words, Miss Wilson is retiring and the newly appointed general secretary accepts with some misgivings the challenge of continuing *Notes from National Office* and other responsibilities to which Miss Wilson has made such special contributions. These are among the very honourable traditions of the Association she has watched over since the establishment of National Office.

We begin the *Notes* this month by bringing greetings to all nurses from the newly appointed staff in National Office. We remember especially those who are overseas and hope that the *Journal* and this message reaches them even in the most distant lands.

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Recommendations of Special Committees

At the meeting of the Executive Committee of the C.N.A. which was held on June 9, 1943, a committee was appointed to confer with representatives of the Canadian Hospital Council regarding vital matters connected with nursing service and to formulate plans for whatever steps were deemed advisable to meet problems connected with these. The personnel of the committee included Miss F. Munroe (chairman), the Reverend Mother Allaire, the Reverend Mother Allard, Misses M. Lindeburgh, M. Baker, G. Hall, E. Flanagan, E. Beith and K. W. Ellis.

As a result of this study recommendations were first discussed with representatives of the Canadian Hospital Council and later presented to the Executive Committee of the Council prior to its biennial meeting held in Ottawa in September. The recommendations formulated with a view to supporting the stabilization of existing general duty staffs include the following:

1. The minimum salary for general staff nurses will be $100 per month in addition to the meals taken during the hours of duty. The nurse will pay for her own room. Laundry will be provided.

nurse a live opportunity for record-writing.

5. The student nurses learned to look upon supervision as a means of constructive guidance and as an integral part of every planned programme.

6. Evaluation, being continuous, gave opportunity for development of each student, and the final evaluation, being a composite report made up by several workers, tended to eliminate subjectivity.

Blue Serge Ladies

It is a most successful operation. That is it will be if the Nurse survives. She hasn't many days of her years. She has just left her hospital training school behind her. She cannot have much experience. This is not said in criticism. It is said in profound admiration of one of our younger generation who is tackling a big job, no less than that of medical and nursing adviser for a municipality.

The Department of Public Health would have preferred a nurse with experience, but those sort are not to be had. They would have preferred a doctor, municipal or otherwise, but these are not to be had. The girl in the blue serge, with the temperamental grey car, and the leather case is the answer.

Cartier municipality has provided a centre for her, perhaps with the vague idea that sometimes she would be in residence. She is, when she is not called out. There are scales there for babies and for adults, a cupboard with nursing supplies which may be loaned out, even including sheets and towels. There are shelves of drugs and rolls of absorbent cotton. There is even a long table with its padded cover, though we do not think that "Nurse" undertakes operations, not major ones anyway. That office is a combination of nursing station, pharmacy, and doctor's office. And just one girl in charge.

The Public Health Department is not pretending that this is an ideal set up. It is an emergency stop gap, with a young blue serge lady holding the line.

These nurses have municipal committees to help them, and sometimes they do. They hold well baby clinics once a month where the mothers can bring their pre-school fry. They hold clinics for immunization inoculations, against smallpox, diphtheria, and whooping cough. Our "Nurse" had had a hundred small folks at the one organized there and there would be others. Our "Nurse" also is going to have a dental clinic when the harvest is in. She has a hundred dollars put by for it. That money was secured by community endeavor by the corn roast route. Another community had raised the money for the sick loan cupboard equipment, and still another had presented the centre with six layettes.

The nurse in these municipalities has the schools under her care. There are twenty-two of them in Cartier. She visits them and examines the children for a long list of things which small flesh is heir to. Defective vision, for instance. Already four children in Cartier have been fitted with glasses, three sets of which were paid for by the parents concerned, and the fourth was secured by the efforts of the neighbors — raffling a pair of pillow cases, if you must know.

The Nurse has charge of the T. B. cases in the municipality, the list being furnished her from the department. She

follows up cases, looks after contacts even after the patient has been taken to the sanatorium, and generally teaches health in the stricken home. Indeed she is at that all the time, not only in the more or less formal classes at the centre and in the schools, but on each visit and indeed at every meeting. She is also a whole battalion in the venereal disease campaign.

We were only with her for a few hours, so haven't yet penetrated the mystery of when she gets a complete meal, or any sleep. At luncheon we had only got to the dessert although we will admit the fried chicken course was only a delightful memory when she was sent for. A man had caught his finger in the threshing machine with not too good results. At supper she couldn't have got more than one bite and a gulp of tea, when she was called to a youngster some miles away who had "an awful pain". For the first call, away from the Centre, a two-dollar fee is charged. The follow-up is free. Just how this call turned out we cannot say for the last we saw was the grey car getting under way.

"I do not know how we managed before she came", asserted a resident to us. Well, we don't know either.

—KENNETHE M. HAIG
in the Winnipeg Free Press

A Problem in Rehabilitation

HELEN LARKIN

The Samaritan Club of Toronto has as its aim the prevention of tuberculosis and the giving of practical assistance to the needy who have been in contact with the disease. A survey was recently undertaken under the auspices of the Club because it had been noted that, in the central part of the city, almost one-third of the referrals had been single or unattached men. It was suggested that the findings be interpreted from the point of view of their interest to nurses and this is herewith attempted.

During a three-year period 190 single or unattached men have been referred. "Unattached" has meant that a man was separated from his family. Some had left their homes during the depression years because of the unhappy situation created when they had been unable to support their families. Others had found, on their discharge from sanatorium, that their wives, partly because of their fear of tuberculosis, had been unwilling to re-establish a home. Referrals come to us usually from one of three sources: the medical officer of health, the public health nurse and, less frequently, from the patient himself.

Prior to their illness the majority of these men lived in rooms, many of them in hostels. Since July 1938, when the Sanatoria for Consumptives Act was revised, the municipalities in Ontario have been responsible for the care of needy patients ready for discharge. In Toronto they have been placed in boarding homes, known as tuberculosis after-care homes, which are supervised by public health nurses. Usually we have our first direct contact with these men following their placement in one of these homes.

Of the 190 patients observed, 93 were Canadians and 23 came from other parts of the British Empire. The remaining 74 came from 18 different countries, 19 of them from China. The variety in racial background appears to be indicative of the known fact, which so many people, descendants of early

settlers, refuse to accept, namely that Canadians are now a people of many racial backgrounds. The age groups at time of admission to Sanatorium were as follows :

10 to 20 years: 12; 20 to 30 years: 45; 30 to 40 years: 40; 40 to 50 years: 39; 50 to 60 years: 25; 60 to 70 years: 11; over 70 years: 1; unknown: 17.

Having heard so much of the dangerous 'teens and twenties, it was surprising to note the ages of admission to Sanatorium of this group, and especially the almost equal numbers in the decades 20 to 50. The National Tuberculosis Association 1939 pamphlet states that the largest toll in women is from 15 to 29, and in men from 45 to 59, thirty years later than in women. From a preventive and teaching point of view, this would seem to be a fact that the nurse should bear in mind. One would expect that people who had been contacts would also wish to be made aware of it.

Occupations prior to admission to Sanatorium were as follows : semi-skilled trades: 26; labourers: 25; restaurant workers: 18; odd jobs: 14; drivers and motormen: 9; white collar jobs: 9; factory workers: 7; sailors: 5; farmers: 4; barbers: 4; school: 3; miner: 1; unknown: 65. It has been stated authoritatively that, although a few occupations are hazardous for tuberculosis, it is the wage level and the standard of living which it makes possible which is the chief influence; also that there are eight times as many deaths among unskilled workers as among professional men. As to the wage level, we did not have complete statistics regarding employment but 57 of these men had been unemployed prior to their illness. One cannot help but feel that the battering about, the irregular and uncertain meals, the inadequate clothing, and the over-crowded and uncertain living quarters of the depression years were directly responsible for the illness of many of them. As to occupational influence, our figures seem to bear out the fact that the majority lacked special training for their jobs.

The statistics regarding return to sanatorium seem discouraging from the point of view of the patient, and also from that of the taxpayer. They only bear out other statistics as to relapse. The point that really stands out is the urgency for early diagnosis and treatment and that the earlier the diagnosis the better the prognosis.

Nurses know that there are three general types of diagnosis in pulmonary tuberculosis, namely minimal, moderately advanced, and far advanced. Do they know that in minimal tuberculosis there is an excellent chance of almost complete recovery; in moderately advanced less so, and in far advanced still less chance of return to good health? Minimal cases often show no symptoms whatever but an x-ray will reveal the trouble; this type of case may need treatment for a few months only.

Everyone should know that there are simple and inexpensive ways to test for tuberculosis. The method with which we are familiar is the I. C. test which indicates reactors, who are then x-rayed. Portable equipment and the 35 m.m. miniature and quite inexpensive film may be used. If trouble is indicated a larger x-ray is taken.

All ex-patients resent the attitude of fear towards themselves but they are helpless to do much about it. Most of them are punctilious about staying out of homes where there are children. They excuse the attitude of the public only because they know that prior to their admission to sanatorium they had been equally ignorant. In order to change this attitude, could not the nurse stress the following facts: first, that all adults should avoid prolonged and intimate contact with the grossly careless tuberculous person but there is little to be feared through ordinary contact;

second, that most adults have been exposed to infection in childhood in small doses and an immunity has been developed. An adult should be taught to build up his defence against the germs already in him, to avoid other diseases, overwork, under-feeding, poor housing and dissipation. He should be taught to seek rest, sleep, good food, fresh air and moderate, temperate, healthful living. The nurse could also explain that while in sanatorium the patient receives an education in healthful living. They are told that for the first few years after discharge they may work or play, but they cannot do both and that they should seek light, sheltered indoor employment. They know that their condition is arrested but not cured. A surprising lack of understanding has been noted where one would least expect it. For example, the case of a young expatient who worked in a store without rest periods and who was asked to stand all day. Of course, this young man had to return to sanatorium. Now he is extremely bitter about his breakdown which he attributes to the thoughtlessness or selfishness of his employer, and this time he refuses to study or think of preparing himself for life outside. We have known a number of men who were so irritated because they were considered lazy or shiftless that they have undertaken work beyond their strength and before long have had a relapse. Some men have been so conscious of the ostracism of the community that they have been relieved to return to the sanatorium.

It is recognized that the man who has done a heavy unskilled job cannot return to this type of work and the necessity for specialized training is an unquestionable need. As well as regaining his physical health, the man of this type has the additional handicap of having to acquire a new occupation if he is to be self-supporting again. Many of these men, however, have spent their time in sanatorium without making any preparation mentally for their return to the community. We have noted two distinct types of reaction—one where the man has dropped into an apathetic state—the other (and this has been learned only when one has come to know the client quite well) where he is desperately turning over and over in his mind ways and means by which he may become self-supporting.

One plan which is being worked out successfully in the United States is that rehabilitation shall commence soon after the patient is admitted to sanatorium unless he is hopelessly ill. His occupational background is discussed, aptitude tests are given and plans for study made. Only this week a client in one of our tuberculosis after-care homes, having heard of the aptitude tests for vocational training given in our army, asked if such a test could be arranged for him. Anyone who has had much to do with ex-sanatorium patients will know how much time is spent by these patients sitting about with nothing to do, no money to spend, few friends, little church or social life. It seems to be a matter of decency to human beings to do something about it.

In closing, may I suggest that the nurse take advantage of the present day trend to work with volunteers. I would like to refer to our own organization. Apart from our executive secretary, three case workers and an office secretary, the club is made up entirely of volunteers. There is a senior board of 60 members who direct all matters of policy; added to their administrative functions, the Board makes possible special nourishment in the form of milk tickets and grocery vouchers to be sent wherever needed. We also supply many patients with vitamin preparations which are lacking in the diet of the average Canadian. There is the junior branch of the Samaritan Club with 90 members who are mostly young married women,

and who have done outstanding educational work. This year they are in the advance guard, having recently arranged that every member and her children shall have the I. C. test and, if necessary, further examination and treatment. The city is divided into twenty-four districts, each with a district leader whose duty it is to collect an annual fee of one dollar and there is a city membership of over 1,200. These outside members have little to do with the actual work of the club but their interest is aroused through an occasional district meeting and through the annual report which they receive by mail. With an active committee to lead and to arouse public interest, this method for raising funds could be used in almost any community. Prevention and rehabilitation work could go hand in hand and the attitude of "I hope I never have anything to do with tuberculosis" could be changed to "Tuberculosis is preventable. Let's face the facts and find out how it can be done".

Making the Front Page

Once upon a time the fat and prosperous journals, published by various hospital groups, were inclined to relegate nursing service to the back pages, neatly sandwiched in between advertisements of laundry machinery and battleship linoleum. Those were the days when nurses seldom if ever "made the front page". Perhaps because blessings seem to brighten as they take their flight, nurses now seem to be coming into their own and, in the September issue of *The Modern Hospital*, there is a portfolio of no less than twenty-six pages, devoted almost exclusively to nursing service and nursing education.

This portfolio contains some very plain talk, much of it from nurses themselves, and deals with conditions of employment that have made it difficult for hospitals to attract and to retain the services of a stable and competent nursing staff. Another article, written by the president of a college for women, tells us (as we already know from sad experience) that student nurses who have completed high school are sometimes "unable to write a complete sentence, can't multiply or divide, and don't understand decimals either". Well, here is *one* problem that neither hospitals nor schools of nursing can reasonably be expected to solve but are justified in politely handing back to the teaching profession for appropriate action. Judiciously mingled with these salutary if critical findings, are some thoroughly constructive statements bearing on such subjects as the use and direction of the Cadet Nurse Corps.

This portfolio renders a real service to hospital administrators and to nurses because it honestly tries to get at the root of the matter and gives positive proof that hospital administrators in high places are no longer taking nursing service for granted but are beginning to understand the importance of fostering and conserving it. One good turn deserves another and, although we can't promise anything so ambitious as this portfolio, an early issue of the *The Canadian Nurse* will offer a modest tribute to hospital administrators (and editors of hospital journals) who try to give nursing service a fair deal.

Notes from the National Office

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As a result of this study recommendations were first discussed with representatives of the Canadian Hospital Council and later presented to the Executive Committee of the Council prior to its biennial meeting held in Ottawa in September. The recommendations formulated with a view to supporting the stabilization of existing general duty staffs include the following:

1. The minimum salary for general staff nurses will be $100 per month in addition to the meals taken during the hours of duty. The nurse will pay for her own room. Laundry will be provided.

Nurses who continue to serve for a second year will be granted two weeks vacation with pay. Two weeks sick-leave with salary will be allowed annually but it is understood that this is not to be cumulative.

2. General staff nurses who are employed for more than one week but for less than one month will be paid at the rate of $4 per day in addition to the meals taken on duty. Laundry will be provided. The nurse will pay for her own room. If the nurse is employed for less than one week she will be paid at the prevailing private duty rates and allowed one meal free of charge when on duty.

3. The hours of duty for all general staff nurses will be eight per day, exclusive of meal hours. There will be a six-day week and the hours will be consecutive whenever possible.

In order to utilize present and other available nursing resources for strictly nursing duties it is further recommended:

1. That every effort be made to avoid wastage of nursing time and effort by the elimination of non-nursing duties and simplification of nursing procedures.

2. That the services of the private duty nurse be limited to those patients whose condition justifies individual nursing care. It would seem that the appropriate control of the use of the private duty nurse should be a matter of arrangement between the attending physician, hospital authorities and the professional registry, and that available nursing resources should be taken into consideration in each instance.

3. That consideration be given to ways and means of minimizing wastage of nursing service caused by shortage of maids, orderlies and aides.

4. That immediate and increased use be made of subsidiary nursing groups.

Other special recommendations related to the increased use of subsidiary nursing groups and included: the continued use of volunteer workers whenever possible; the formulation of plans by provincial nurses associations, in cooperation with representatives of provincial hospital associations, for the preparation, definition of duties and appropriate control of subsidiary nursing workers. It was recommended that these workers be known as nurses' aides.

Members of the Committee of the Canadian Nurses Association expressed themselves as opposed to the "freezing" of nurses, but referred to the fact that the Association has already endorsed a policy recommending that nurses be required to remain in nursing.

Recommendations Relative to Post-graduate Work

This report is the result of a joint study made by the Committee on Nursing Education and the Hospital and School of Nursing Section, C. N. A. These recommendations which have been approved by the Executive Committee of the C.N.A. are of special importance at the present time when the strengthening of postgraduate courses is suggested as one mean of overcoming shortages in nursing service, especially in sanatoria, mental hospitals and other special fields. It is felt that through well organized postgraduate courses the interest of nurses in these services will be stimulated and sustained.

Standards for postgraduate clinical courses:

1. Entrance requirements should be set up by each school individually and a definite certificate should be awarded upon the completion of the course.

2. The curriculum should clearly indicate the nature, scope and duration of the theoretical instruction and the clinic-

al experience that is afforded to the student.

3. The essential constituents of the students' programme should include classroom instruction, clinical experience and time for study.

4. The combined class and clinical work should not exceed 35 hours per week while classes are in progress. When classes are not being held, the clinical work should not exceed 40 hours per week nor be less than 30 hours per week.

5. The time allotted to study should be 12 hours per week when theoretical courses are being given.

6. Clinical experience should be so planned that it will cover the various aspects of the specific course that the student is taking.

7. The student should not be considered as a paid member of the staff and should only be assigned to duty in the service (and at the time) that will be of most benefit to her.

8. A member of the administrative staff of the school of nursing should be responsible for the direction of the course. At least one nurse member of the teaching staff of the school should give formal classroom instruction and at least one nurse member should give organized clinical instruction. Organized classroom instruction in the major subject of the course should be given by medical lecturers and by other lecturers in allied subjects.

9. Clinical experience should be planned by the responsible nurse member of the administrative staff in consultation with a member of the teaching staff. This experience should be planned in a definite sequence and for the benefit of the student.

10. The combined hours of instruction and clinical work should not exceed eight hours daily and should be limited to 96 hours in the fortnight.

Further recommendations read as follows:

1. That postgraduate clinical courses be approved (a) in university schools of nursing where the above standards are met; and (b) in hospital schools of nursing where the above standards are met.

2. That institutions offering courses for graduate nurses differentiate clearly between added experience on the student level and postgraduate experience on the graduate level.

3. That institutions offering postgraduate experience set up their courses in terms of objectives or desired outcomes, these objectives to be an integral part of the total plan submitted.

4. In the event (as is usually the case) that the existing service load of the classroom and clinical instructors does not permit additional burdens, a full-term qualified instructor be employed to conduct the postgraduate course.

Special Greetings

A message to the provincial secretaries is in order especially at this time when changes have recently taken place affecting these officers in several provincial associations. We are very happy to have this opportunity to pay tribute to those who are retiring from office and to welcome the incoming executives. The former are leaving enduring testimonies of the contributions they have made in building the future of nursing in Canada. It is reassuring to know that in several instances these nurses are continuing in the profession. To the incoming officers we extend very cordial wishes as with them we undertake a journey into new fields of endeavour that are ripe with opportunities and so full of challenge.

"Austerity! Hard Work and Simple Living"

An appearance of almost unreal fragility, a crest of soft white hair brushed upwards from a face that has acquired the pink and white transparency of extreme old age, a pair of direct blue eyes, and a serene smile of welcome — I was looking at Rebecca Strong, 100 year old, whose name is a legend in the history of nursing.

She was the first nurse ever to take a patient's temperature. She used a thermometer that was two feet long and shaped like a shepherd's crook, and she was severely reprimanded for her audacity. It was the first small reform of a lifetime spent waging endless battles against those firmly entrenched in the belief that the sights and sounds and smells of the hospital ward were not for women, except in the most menial capacity.

Sitting tremulously erect, in an armchair covered in flowered cretonne, in the quiet grey house among the green fields of Cheshire, where she is living out her days with her great-nephew and his wife, she told me of her early days, the days when Victoria was a youthful Queen, when Charles Dickens had just begun to write his novels, when David Livingstone was the hero of African exploration.

As she spoke her face lit with some of the fiery spirit of the young girl whom Florence Nightingale inspired by personal instruction. The Crimean War was over. It began when Mrs. Strong was a child of 10 but she read in the formal newspapers of the day of the exploits of the heroic band of women who reduced the death rate among the wounded soldiers in the Crimea from 420 to 22 per 1000. Perhaps it was then that the passion for nursing first took root in her mind. She married in her teens. At 20 she was widowed and had a baby daughter. Soon after, both her parents died and in 1867 she entered the Nightingale School. Doctors all had beards then and wore top hats and frock coats. Nurses had no special uniform. They performed the elementary duties of making sick people comfortable while in bed, and were not considered fit for much more. Cleanliness was not yet completely established as one of the primary rules in successful treatment of the sick. Nurses might receive a few stray lectures, but their knowledge of dealing with patients had to be picked up in the best way they could.

In 1874 she was appointed matron of Dundee Royal Infirmary, and in 1879 she came to Glasgow Royal Infirmary, where she spent the rest of her nursing life. She told me with a chuckle of one of the crises in her life. She wanted a home for the nurses instead of having them living and sleeping anywhere, most often just off the wards with their population of sick and dying. "But that was too much", she said. "I was told I had gone too far. The proposal to have a nurses' home was revolutionary. I had to resign". But she came back when the nurses' home had been built and immediately began to devise, in co-operation with Sir William Macewen, the eminent Scottish surgeon, who was her life's hero, a scheme for the education of nurses, which has been the basis of nurses training all over the world ever since.

After her retirement in 1907 she travelled extensively. She met Mussolini, and made friends with an Italian princess with whom she corresponded about nursing for many years. She ran a nurses' home in Jerusalem. She went to Ceylon, Canada, and America. One of her prized possessions is the feather

from the head-dress of a Red Indian chief presented to her at a jamboree held in her honour at Banff, in the Rocky Mountains. She wears a Chinese hand-embroidered dress-front sent to her by a Chinese nurse.

She is the grand old lady of nursing. But her greatest admiration and affection is for the modern girl, especially nurses. To use her own words, she thinks they are "marvellous". When asked her recipe for attaining the century, she replied at once with a twinkle in her eyes — "Austerity! Hard work and simple living".

Editor's Note: This tribute to Mrs. Strong appeared in the Glasgow "Bulletin" and was written by a woman reporter who had the privilege of interviewing her. The *Journal* is indebted to Miss Grace M. Fairley for sending us this delightful sketch of "the Grand Old Lady of Nursing".

The New Order in Britain

Mr. Ernest Bevin, M. P., Minister of Labour and National Service, has made a new order which concerns the nurse and is really an amendment to a previous order which controlled the engagement of women. This order made it necessary for all women between the ages of 18 and 40 years to obtain employment through a local office of the Ministry of Labour. There were certain employments which were exempted from the application of the order and the professions of nursing and midwifery were among them. The new order cancels this exemption with certain reservations because of the present serious shortage of nurses in certain hospitals and fields of work. The Minister has also announced the policy which he proposes to follow in putting the order into force.

No nurse or midwife between the ages of 18 to 40 years will be able to obtain employment in future except through the local appointment offices, unless the position she wishes to apply for is that of a ward sister or any higher position in hospital, or is of the supervisory grades in the domiciliary nursing, midwifery or public health services. In this way the Minister hopes to ensure a better distribution of nurse-power.

In the first place, since staff nurses can only obtain vacancies through the local appointment offices, the officers who staff them can tell applicants where their services are most needed: in each district there will be local advisory councils which will advise the officers on the question of priority. If nurses are particularly needed in a sanatorium or a fever hospital, the applicants will be asked to go there for a period of time. If the nurse does not stay she must come back to the appointment office to obtain further employment. This will enable the officers to find out why she has not stayed. If there is a good reason for her leaving, they may be able to correct it and improve conditions which are really unsatisfactory. If there is no good cause, since her leaving must be reported to them, they can call her for interview, and offer her such work as they feel she should undertake.

It is scarcely likely that the work will be easy or will get into its stride without some preliminary difficulties and misunderstandings. We hope difficulties will not come from the nursing profession unnecessarily. Every nurse realizes that at this moment the nation is carrying out with no little success a very difficult undertaking which depends for

its success on the full co-operation of everyone of its citizens. It is essential that each one of us should put our shoulders to the wheel just where leverage is most needed to carry the country through to victory. Yet, as individuals, we cannot see the picture as a whole. We live, each one of us, in our own little world to a large extent, and do not realize where the strains are greatest. The Minister of Labour can see the picture as a whole.

For the newly qualified State-registered nurse, who will perforce find employment through the local appointments offices, we could wish the Ministry of Labour could offer a wider experience scheme, under which the nurse would serve, in one year, for four months in hospitals offering different types of experience. Each nurse who chose to work under such a scheme might select three types of specialized work from among the following: tuberculosis nursing, infectious diseases nursing, mental nursing, and nursing of the chronic sick, and, provided the medical staff would co-operate by giving lectures, there might well be, with good organization, real enticement to gain insight, knowledge and experience in different fields of work. Since the training of the nurse in the future may well develop on similar lines, and provide such experience in the basic training, the intelligent young nurse should jump at such an opportunity. The local advisory committees which have been set up and are already functioning should be able to help to make such a scheme successful and guide nurses into it.

What is the Minister's policy? Guided by the National Advisory Council for the Recruitment and Distribution of Nurses, two points have been made clear. The most important concerns the midwife for, with the increased birth-rate and the great shortage of domestic help in the home, increasing hospital confinements, this problem is one of the greatest. Newly-qualified midwives (those candidates who complete the second six months of the midwives training) will be required to practise in the profession for a year. Some will perhaps consider this a hardship, especially if they had not intended to practise. On the other hand, if they did not intend to do this, they should not be taking the second part of the training.

There will, of course, be the old cry, "She should never have taken the training; she only did it to obtain an additional qualification so that she would be able to obtain matron's appointments later". This may be true of a few ambitious persons. We do not think it is true of the majority. The intelligent nurse feels that, like the doctor, her training is incomplete unless she can cope with the delivery of a woman in labour, since she meets pregnant women with pneumonia, appendicitis, empyema and similar conditions among her ward cases, and knows that premature labour may result. She seldom realizes that a committee twenty years hence may demand the C.M.B. certificate when appointing the matron of a general hospital.

Another step concerns the private nurse. Private nurses already in practice will be able as individuals to obtain permits to enable them to seek their own employment. The co-operation or agency cannot obtain these permits for its nurses. The permits will hold good for a limited period only, probably three to four months in the first place, and will then require renewal. Private nurses will only be able to obtain permits if fully employed, which, we understand, means that they are employed for at least ten and a half months in the year. They will not receive permits if they are under thirty years of age, except when there is some special reason.

The new order curtails the freedom of nurses and midwives temporarily. Unlike Hitler's "new order", it will not curtail it permanently. We do not think

there will be much complaint. Many midwives, rightly or wrongly, have wanted full midwifery training to be reserved for midwives intending to practise. This wartime experiment will show whether the restrictions will not diminish the supply by making a certain number fearful to start, lest they find themselves tied to a profession they feel they cannot practise yet would actually be very good midwives and love the work. Apart from this, nurses already realize that some sacrifice of personal liberty now is something they must willingly share with other women in the Services, in other professions, and in industry for the greater liberty of the nation when victory is won.

—*The Nursing Times*

The McGill School for Graduate Nurses

The fourth war-time session at the McGill School for Graduate Nurses opened on September 30 with a class of fifty nurses, registered in the four major courses offered. Once more, in spite of increasing difficulties, hospital and public health agencies have found it expedient to release members of staff for these courses, in order to be able to meet more adequately the staff problems of the future. As a matter of interest, the group represents every Province, and the enrolment in the various courses is as follows: administration in schools of nursing, 3; administration and supervision in public health nursing, 8; teaching and supervision in schools of nursing, 15; public health nursing, 24. Many of the students have received bursaries from the Federal Government grant to help them in financing this further preparation for their chosen field of nursing service.

Financial aid from the same source has made it possible for the staff of the School to be strengthened by the addition of one full-time assistant, and two half-time instructors. The full-time assistant, Miss Kathleen Stanton, is a graduate of the School of Nursing of the Royal Victoria Hospital, Montreal, and of the School for Graduate Nurses. In addition, she has a bachelor of science degree from St. Francis Xavier University, Antigonish, N. S. For the past four years Miss Stanton has been a member of the teaching staff of the School of Nursing of the Royal Victoria Hospital. She is well fitted by preparation and experience to assist in the development of the course in teaching and supervision in schools of nursing. Her enthusiasm, happy disposition, and a genuine love of nursing, should enable her to make a real contribution to the School.

To meet the increasing load in the

KATHLEEN STANTON

public health nursing programme, Miss Marion Nash and Miss Ethel Cooke have been appointed as half-time instructors. Miss Nash, educational director of the local branch of the Victorian Order of Nurses for Canada, is a graduate of the Western Hospital of Montreal, and of the public health nursing course at McGill. She also has a bachelor of science degree from Columbia University. The third new member of the staff is Miss Ethel Cooke, who graduated from the School of Nursing of the Montreal General Hospital, and who also holds the McGill certificate in public health nursing. Miss Cooke is supervisor of the Teaching Centre of the Child Welfare Association in Montreal. Miss Nash and Miss Cooke will devote most of their time to the supervision of field work and the closer integration of theory and practice throughout the course. The fact that both of these instructors will remain in the service field will be most valuable in the further development of the public health nursing programme of the School.

In addition to the major programmes, it is expected that the four months course in supervision in special clinical fields will be offered during the second term. This course was given for the first time last session in order to meet the insistent demand for more and better supervisors in the clinical specialties. All of which leads to the conclusion that, despite the augmented staff, the session of 1943-44 will be a busy one.

Public Health Nursing in Newfoundland

The annual report of Syretha Squires, Director of Departmental Nurses in Newfoundland, is always a stimulating record of devoted and efficient service. Although the nursing staff has been depleted, an enormous amount of work has been accomplished. The outlying districts have suffered greatly from shortage of nurses although married nurses living in the adjacent areas have been brought back into service on a part-time basis and are doing excellent work because they are a part of the community and know every family in it. Strange demands have to be made upon them at times, as is evidenced by the following quotation from a letter written by a public health nurse: "My latest patient was a cow and thereby hangs a tale! It was a case of adherent placenta and ergot totalling 4 ounces was administered with good results. Prontylin grs. 80 were given daily. Cow and calf are convalescing nicely." From our most northern district a letter came during the latter part of June which says: "The ice is still staying around and keeping the temperature down, as well as making it impossible for the men to get at their fishing. Vegetables are getting scarce and it will be a great treat to get some fresh fish and be able to look forward to putting in some lettuce seeds. We are praying for a boat to come along soon. We have no news so far and are a little anxious. However, we must be thankful that things are going as well as they are." All the nurses' letters are cheerful and tell of high courage in the face of difficulties.

The Cottage Hospitals and nursing stations are under-staffed but are carrying on in the true British manner. These posts call for the services of mature and experienced nurses since the duties include the giving of anaesthe-

tics and responsibility for both nursing and housekeeping. Nevertheless, the younger nurses are filling these positions and their work has been most commendable. Unfortunately, the hospitalship "Lady Anderson" has been laid up due to difficulty in procuring new parts. Her absence has been keenly felt by the people whom she served but it is hoped that she will soon be going full steam ahead on her mission of mercy.

The prevention of tuberculosis is an outstanding activity of the Department and this work is still being actively carried on. The nurses have a fine appreciation of the value of tuberculosis visiting and this is bearing fruit, resulting in greater co-operation from the patient and his family. There is said to be a great need for some institution where far-advanced cases may be cared for, especially when a large family is exposed to this focus of infection in the home. Four weekly clinics are held under the auspices of the Venereal Disease Clinic. More suitable quarters have been found for the female clinic and there is consequently an increase in attendance. Both male and female clinics are now offering much better treatment because of the improved facilities.

Each public health nurse is responsible for the schools in her own district; during the past year 7490 children were examined and of the 489 defects found, 400 were corrected. The Avalon Health Unit undertook a survey of the schools in the municipal area of St. John's with tuberculin testing of all school children. This project entailed a great deal of follow-up and track-down work for the nurses, resulting in case-finding and in better contact with the home and family. A new nursing district was opened in St. Mary's because there was no prospect of securing a doctor. It was felt that so large and isolated an area should not be left without any medical service whatever and it was decided to station two nurses in the district. This service is on a contributory basis and the response from the community was most gratifying.

Nowhere in the British Empire is there a greater challenge to public health nurses than in Newfoundland and the nurses of the Department of Public Health and Welfare have risen to the occasion magnificently.

In Memory of Muriel Harpell

The Montreal General Hospital School for Nurses has recently received a very valuable bequest. The late Muriel K. Harpell left to her Alma Mater her library, which was presented to her by her father on the occasion of her graduation in 1936. The collection includes with the essential nursing texts, the twenty-four volumes of the fourteenth edition of the Encyclopaedia Britannica, a copy of the completely revised unabridged Webster's International Dictionary and many important books of reference. Several biographies are included among them being Harvey Cushing's Life of Sir William Osler.

The volumes were accompanied by a bound copy of "A Nurse's Remembrance of her Alma Mater". In this book we find a photograph of Miss Harpell, the dedication of her gift, a letter to her from her parents on the occasion of her graduation from the School of Nursing, and a copy of the "Address to the Graduating Class" by the late Dr. S. Hanford McKee. The books were presented to the School in a combination bookcase and reading desk.

The library will serve future generations of nurses, and will form a fitting memorial to the fine nurse and brave woman whose gift they are.

STUDENT NURSES PAGE

A Case of Werlhoff's Disease

ADA MARGARET MACGREGOR

Student Nurse

School of Nursing, Toronto East General Hospital

A most interesting case presented itself at the Toronto East General Hospital when Mrs. X, a woman of 30 years of age and the mother of three children, was referred for admission from the emergency department of the hospital. This patient's history revealed that she usually enjoyed good health and had been perfectly well until February 12 when she developed a cold. Eight days later this cold disappeared and she suddenly began to bleed from the nose and gums. The bleeding could not be controlled by packing of the nose or by any other measure. She had had no previous nose-bleeds, haematuria, haematemesis or haemoptysis but stated that she bled for lengthy periods when injured and bruised very readily. A physical examination revealed extensive bruises over the entire body and a few small purpuric spots. The lips were covered with haemorrhagic blisters; blood was oozing from the dental sockets. The teeth showed extensive caries and absence of oral hygiene. Blood was also oozing from the mucous membrane of the nose. There was a slight elevation of temperature.

An examination of the urine, which looked almost like pure blood, showed 4 plus albumen and an abundant number of red blood cells. The hematological findings showed haemoglobin 61% compared with the normal which is between 80% and 100%; a red blood count of 3,900,000, normal being 5,000,000; a white blood count of 55,000, normal being between 7,000 and 9,000. The platelet count was 10,000 compared with a normal count of between 250,000 and 350,000; the coagulation time was 3¼ minutes, the normal is from 2 to 9 minutes. The bleeding time was 50 minutes, the normal being from 3 to 6 minutes. There was no clot retraction within 24 hours.

A careful enquiry was made as to whether the patient had been taking any medication, or if she had been exposed to any toxic substances in connection with her daily work that might have been the cause of her condition, it having been proven that idiosyncrasies to certain drugs or substances are factors in causing some haemorrhagic conditions. In this case, no drugs or substances were traceable to which the condition could be attributed. Her diet had apparently been somewhat lacking in Vitamin C, the antiscorbutic vitamin which occurs in large amounts in fresh fruits and vegetables.

After a detailed study of the symp-

toms and a careful consideration of hematological findings, this case was diagnosed as idiopathic thrombocytopenic purpura or Werlhoff's disease, a disease characterized by multiple haemorrhages from the skin or mucous membrane, with a reduced platelet count, a prolonged clotting time, and a normal coagulation time. This disease was first described in 1735 by a German physician, Paul Werlhoff. In 1910 it was clearly demonstrated that the haemorrhages resulted from a decrease in platelets. Platelets play an important part in the coagulation of blood and when the number falls below 350,000 haemorrhagic tendencies usually develop. This disease is world-wide, occurring in no significant geographical, racial, seasonal or occupational incidences. It occurs in all ages and both sexes, the average age having been shown to be 19 years. It also seems to be four times as prevalent in females as in males. The disease usually runs a course of remissions and relapses, with eventual cure in some patients either by surgical or medical methods. It occurs in both chronic and acute forms, the chronic type being the more common. There are variable haemorrhages from the skin and mucous membrane. Haemorrhages may occur as nose-bleeds, post-operative bleeding, excessive or prolonged menstruation, bleeding from the gums or dental sockets, haematuria, intracranial or retinal bleeding.

Treatment and progress: The calcium of the blood is its most important inorganic constituent and is essential to life because it is necessary for blood clotting. Mrs. X. was therefore given ten grains of calcium lactate orally three times daily during her stay in hospital, and received six subcutaneous injections of Vitamin K, the vitamin that is essential to blood clotting. A diet high in Vitamin C was ordered because it is believed that a deficiency delays the clotting of blood and reduces the number of platelets in the blood.

Blood transfusions are most effective in remedying disease of the blood and these constituted the major treatment. The patient received citrated blood as well as direct transfusions; it was felt that her response to the direct method showed it to be the more effective. She was given three transfusions, each consisting of 500 c.c. of citrated blood, followed on February 27 and 28 by small direct transfusions of 150 c. c. and 170 c.c. respectively. Following these, the the bleeding time fell gradually from 50 minutes to 40, 25 and finally 4 1/3 minutes; the platelet count rose from 10,000 to 320,000. The urine which, the morning before the transfusion showed blood, contained only a few red blood cells on microscopic examination in the evening. The patient's condition steadily improved and the bleeding became less and less profuse until, on February 28, it stopped entirely. Her condition seemed so much improved that she left the hospital contrary to the doctor's advice on March 17, with a platelet count of 217,000 a normal bleeding time, and a clot retraction time of 45 minutes.

On April 2 Mrs. X. was re-admitted with a recurrence of bleeding from the gums and a profuse menorrhagia. Blood counts showed haemoglobin 52%, R.B.C. 38,000,000, W.B.C. 80,000, platelets 11,000, bleeding time 60 minutes. On April 4 she was given a direct transfusion of 400 c.c. of blood. Subsequently her platelet count rose to 90,000 and the bleeding time dropped to 1½ minutes. On April 6 the platelet count was 102,600 and the bleeding had ceased. This remarkable change seemed rather spectacular and may be attributed to the direct transfusions. An x-ray examination of the teeth showed extensive caries. The removal of any focus of infection is an important step in the treatment of this disease and consequently Mrs. X. was advised to have

her teeth removed. This was done successfully with no bleeding over a period of about three weeks. Mrs. X. is still in hospital and is convalescing but will remain under observation until her next menstrual period.

Depending on the duration of the remissions, other forms of treatment such as splenectomy, snake venom, or parathyroid extract injections may have to be resorted to. Splenectomy has proven to be a really effective treatment; this treatment was introduced on the theory that the spleen was destroying an excessive number of platelets. Following operation there is a great rise in the platelet count; however, it does not eradicate the cause. Mrs. X. responded well to treatment and the prognosis seems good although it must be remembered that recurrence is very common in this disease.

Nursing Care: Mrs. X. was a very sick patient when she was admitted to hospital and good nursing care was essential. She received a daily cleansing bath and alcohol rub which added much to her comfort. The care of the mouth constituted a major problem; there had been absolute neglect of oral hygiene, her teeth were carious, her gums bleeding and swollen, her tongue dirty and dry. There were scattered superficial ulcers on both tongue and lips, the latter being extremely dry and caked with dried blood. It can be easily understood that her mouth was sore and much care had to be taken in attempting to cleanse it. After carefully cleaning the teeth with absorbent, hydrogen peroxide mouth-wash was used at frequent intervals and hazeline cream was applied to the lips to soothe and soften them. Her mouth was sprayed frequently with mouth-wash. After about one week of constant care there was a marked improvement and it was remarkable how much this added to the patient's comfort.

Elimination offered another problem. Strong laxatives were forbidden and even enemata had to be administered with care. An olive oil enema, followed by a small soap-suds enema, was given the third day after admission; small enemata and mild laxatives were given subsequently to ensure regular bowel movements. For the first week the patient's diet consisted only of cold fluids. These had to be nourishing, and orange and tomato juice were given abundantly to supply the necessary Vitamin C. At a later date, a low residue diet was ordered. Appetite was poor at first but gradually improved until Mrs. X. was enjoying her meals and extra nourishment besides. The care of the skin was also important because the patient was obliged to lie quite still at first; alcohol rubs not only added to her comfort but also helped to prevent pressure sores.

Mrs. X. was willing to co-operate with all the nursing measures. She had a happy disposition and a hopeful outlook. This was a great help in caring for her and perhaps added in some measure to her recovery.

Did you Graduate in Quebec before 1925?

An amendment to the Nurse Registration Act of the Province of Quebec makes it possible for any nurse, who has obtained the certificate or diploma of an approved school of nursing in the Province prior to March 19, 1925, and whose qualifications are approved by the committee of management, to register without examination upon production of the certificate or diploma and payment of the registration fee.

Any nurse who wishes to avail herself of this provision should immediately secure

the necessary forms from the Registrar of the Association of Registered Nurses of the Province of Quebec, Ste. 1012, 1538 Sherbrooke St. W., Montreal. Applications must be made before December 23, 1943, when the provision will cease to exist.

A New Institute of Psychiatry in Montreal

The establishment of an Institute of Psychiatry in connection with McGill University and the Royal Victoria Hospital is now well underway. It will occupy "Ravenscrag", the former home of Sir Montagu and Lady Allan, adjoining the hospital property on the mountainside and given to the hospital by Sir Montagu.

The project has the support of the Rockefeller Foundation which is providing $150,000 for the teaching and research aspects of the work. The Government of the Province of Quebec has undertaken to provide $30,000 a year for twenty years, and private citizens are also lending their assistance. The Institute will be used for teaching medical students and nurses and for psychiatric research, as well as for the diagnosis and treatment of mental illness.

The director is Dr. D. Ewen Cameron — a Scotsman and a graduate of the University of Glasgow. His very wide experience has been gained on the staffs of the Royal Mental Hospital, Glasgow, the Phipps Psychiatric Clinic of Johns Hopkins University, and in Zurich under Professor Adolph Meier. Later he joined the staff of the Brandon Mental Hospital in Manitoba and organized mental health work in the western part of the province. In 1936 he went to the Worcester State Hospital as senior research psychiatrist and became resident director of research during the following year. In 1938 he was appointed professor of psychiatry at the Albany Medical College in Albany, N. Y., and psychiatrist-in-chief of the Albany Hospital. He comes to Montreal as professor of psychiatry at McGill University and psychiatrist-in-chief at the Royal Victoria Hospital.

The School of Nursing of the Royal Victoria Hospital welcomes the new department and appreciates the valuable experience which will now be available for the students of the school. It is hoped that it will not be long before a well planned and well administered course for graduate nurses can be offered. A supervisor of nurses has not yet been appointed. It should prove an interesting position for a nurse who has had psychiatric training and is fitted for administration and teaching. The Institute will open about February 1, 1944. Any nurse who possesses the necessary qualifications is invited to apply to the Superintendent of Nurses, Royal Victoria Hospital, Montreal.

Toward a New Horizon

Vers un horizon nouveau — that is the way a French member of the A.R.N.P.Q. expressed herself at the close of a special meeting recently held in Quebec City during which we were keenly aware that we are indeed moving towards a new horizon.

Having secured amendments to our Registration Act which call for a great deal of understanding energy, goodwill and determination on our part, we accepted an invitation to "meet in Quebec before the snow flies". Feeling in our bones that the snow may fly sooner than usual this year, we wisely decided to hold this important meeting in the lovely month of September. Yes, indeed, everything *was* lovely, even the minutest item on the programme, for it was all concerned with a plan to move forward and this time, as never before, we seemed to have a fuller appreciation of the signifi-

cance and meaning of moving *together*. Twelve districts have to be organized according to the terms of our present Act and our Quebec meeting has paved the way for a better understanding of the task involved.

Three sessions were held all in one day so that no one was tired or bored and the minimum amount of time away from duties was expended. In the morning, French and English groups met separately, the former heard a very fine address on "The Function of the Endocrine Glands", by Dr. J. N. Larochelle. The English group met at Jeffery Hale's Hospital where Miss Johns, who on many former occasions has given us much to think about, exceeded all previous contributions. Her plea for greater consideration and recognition of the staff nurse who has served quietly and efficiently, behind the guns as it were, was exhilarating.

The afternoon session held in Hôtel-Dieu was truly bi-lingual — including the speakers, the discussion and the atmosphere. All the new provisions contained in the amendments to the Act were presented clearly and well, and provoked a discussion which warmed the cockles of one's heart. Miss Alice Ahern, chairman of the C.N.A. Committee on Health Insurance and Nursing Service, answered a volley of questions on the mysteries of social security and nursing benefits as they are described in the Health Insurance plans.

Following this session we were the guests of the nursing staff of the Jeffery Hale's Hospital when one hundred and fifty of us enjoyed the hospitality of high tea.

In the evening the groups separated again, the French members meeting in Hospital du St-Sacrement and the English in Jeffery Hale's Hospital. Speakers at the French session were Dr. Renaud Lemieux who delivered a sparkling address entitled "La Garde-Malade", an address given by Miss Johns being entitled "Au-delà des Frontières". Miss Fanny Munroe, first vice-president of the Canadian Nurses Association, and Miss Mary Mathewson, assistant director, School for Graduate Nurses, McGill University, were the speakers at the English session, the former outlining the present trends and activities of the C.N.A. and the latter the significance of the C.N.A. activities in relation to Quebec.

Our president, Miss E. C. Flanagan, presided at the morning meeting in English and at the bi-lingual afternoon sesssion. She was also co-chairman with Mlle Maria Beaumier at the evening French session. Mlle Maria Roy presided at the morning French session and Miss Mabel K. Holt, English vice-president, A.R.N.P.Q., at the English session in the evening. Discussion at this session was also very heart-warming. The general attendance was approximately 300 and we came away feeling that the time had been well and profitably spent, and that more such meetings would do us all a lot of good for, at long last, we seemed this time to get down to brass tacks.

E. Frances Upton

Executive Secretary and Registrar

A Career for the Graduate Nurse

The Graduate Nurse of 1943 is not restricted, fortunately for her, to private nursing duties if she would prefer special services. Among nursing specialties, one of the most fascinating though least understood is the care of the mentally ill. This is a field that will greatly expand as aftermath of war's toll of soldier and civilian mental casualties. The nurse who is well trained in thiis work will find in coming years profitable scope for her ability. In step with medical progress, the asylum for the insane has been liquidated. In its place is the hospital for the mentally ill. The Provincial Hospital of New Brunswick has a yearly admission rate of nearly five hundred and within its walls are twelve to thirteen hundred patients. All wards are supervised by graduate nurses. Besides wards for physically well patients, there is a modernly equipped hospital of a hundred beds with operating room, laboratory, and x-ray, also special

units for hypoglycaemic and electric shock therapy. If you are interested in the field of psychiatry this hospital provides splendid opportunity for experience. The pay is adequate and living quarters pleasant. If you would like further information communicate with the Superintendent of Nurses, Provincial Hospital, Fairville, N. B.

Who is to Nurse the Tuberculous Patient?

The Association of Registered Nurses of the Province of Quebec has recently appealed to its members to help in providing nursing care for patients suffering from tuberculosis. A little more than a year ago, a modern pavilion was added to the Royal Edward Laurentian Hospital but already a large section of it has had to be closed because of the lack of nursing service.

Have nurses relinquished all sense of responsibility for the care of these patients? If not, it is high time that some concerted action should be taken by national and provincial nursing organizations that will help to put an end to this intolerable situation. In the meantime, every nurse who can possibly do so should put her shoulder to the wheel.

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Mrs. Selhorn (Ruth Sheldon), B.Sc.N., University of Alberta Hospital, has returned to the Order and has been appointed nurse-in-charge of the Edmonton Branch.

Doris Renwick, a graduate of Holy Cross Hospital, Calgary, and of the public health nursing course, University of Alberta, has been appointed to the Edmonton staff.

Ellen Holland, a graduate of Victoria Hospital, London, and of the public health nursing course, University of Western Ontario, has been appointed to the York Township staff.

Marion E. Robinson, a graduate of Misericordia Hospital, Edmonton, and of the public health nursing course, University of Alberta, has been appointed temporarily to the York Township staff.

Helen McRorie, School of Nursing, University of Toronto, *Mary Elizabeth Dunsmore*, a graduate of the Toronto Western Hospital, and of the public health nursing course, University of Toronto, *Margaret Mellon*, a graduate of the Toronto General Hospital, and of the public health nursing course, University of Toronto, and *Marjorie Beck, C.M.B.*, a graduate of the Croydon General Hospital, Surrey, England, have all been appointed to the Toronto staff.

Mrs. Fauteux (Lyle Ferguson) has been re-appointed to the Toronto staff.

Grace Arnold, a graduate of the Brantford General Hospital, *Margaret Macdonald*, a graduate of the Toronto East General Hospital, and *Lenore Wellar*, a graduate of the Hospital for Sick Children, have been appointed temporarily to the Toronto staff.

Arminal Hay, a graduate of St. Michael's Hospital, Toronto, and of the public health nursing course, University of Toronto, has been appointed to the Brantford staff.

Mary Henderson, a graduate of the Royal Columbian Hospital, New Westminster, and of the public health nursing course, University of British Columbia, has been appointed to the East York staff.

Helen Bradley, a graduate of the Regina General Hospital, and B.Sc.N. University of Saskatchewan, has been appointed temporarily to the Regina staff.

Gladys Bowman, a graduate of St. Mary's Hospital, Kitchener, and of the public health nursing course, University of Western On-

tario, has been appointed to the Galt staff.

Ruth Blackwood, a graduate of the Ottawa Civic Hospital, has been appointed temporarily to the Yarmouth staff.

Mariette Turcot, a graduate of St. Jean de Dieu Hospital, Gamelin, Quebec, and of the public health nursing course, University of Montreal, has been appointed to the Montreal staff.

Margaret Trueman, B.A., has resigned from the Montreal staff to accept a position with the Department of Public Health, Westmout, P. Q.

Erie Lloyd has resigned from the Montreal staff to join the R.C.A.M.C. Nursing Service.

Jessie Morris has resigned from the Montreal staff to be married.

Frances Winchester has resigned from the Montreal staff to do other work.

Maxine Ward has resigned from the Kitchener staff to accept a position with the Ottawa Secondary Schools.

Elizabeth George has resigned as nurse-in-charge of the Yarmouth Branch to be married.

Claudia Arrand and *Opal Shaw* have resigned from the York Township Branch to serve with the R.C.A.F. Nursing Service.

Bessie Julien has resigned from the York Township staff to take Deaconess training.

Kathleen Reid has resigned from the Edmonton staff to serve with the R.C.N. Nursing Service.

Florence Bell has resigned from the East York staff to accept a position as clinical supervisor at the Toronto East General Hospital.

Mrs. Liddell (Glennis Locken) has resigned from the Winnipeg staff to join her husband.

Mrs. Macklom (Eva Wheeler) has resigned from the Saskatoon staff.

Jean Forbes, supervisor of the Halifax staff, has been granted leave of absence to take post-gradute study in public health nursing at Teachers College, Columbia University.

Alberta Creasor, nurse-in-charge of the Victoria Branch, and *Helene Snedden*, supervisor on the Hamilton staff, have been granted four months leave of absence from the Order and are taking a course in supervision in public health nursing, McGill School for Graduate Nurses.

WANTED

Applications are invited from registered nurses for **General Duty** in a Tuberculosis Sanatorium of 360 beds. When writing please state previous experience, age, etc. The salary offered is $75 a month, with full maintenance.

Address applications to:

Miss M. L. Buchanan, Superintendent of Nurses, **Royal Edward Laurentian Hospital (Ste. Agathe Division)**, Ste. Agathe des Monts, P.Q.

(Formerly — The Laurentian Sanatorium)

WANTED

A **Night Supervisor** is required for a 120-bed modern hospital. The salary is $100, plus full maintenance. Apply, stating age, qualifications, etc., to:

Superintendent of Nurses, Galt Hospital, Lethbridge, Alta.

WANTED

Applications are invited for the position of **Lady Superintendent** for a 40-bed hospital. Applicants will please state age, experience, qualifications, salary desired, and when services would be available.

A **Laboratory** and **X-Ray Technician** and **Operating Room Nurse** are also required. Address applications to:

Secretary, Kentville Hospital Association, Kentville, N.S.

WANTED

Graduate Registered Nurses are required for **General Duty** in a **mental hospital.** Excellent opportunity for experience in Psychiatric Nursing, which includes Electric Shock and Insulin Therapy. For full particulars apply to:

Superintendent of Nurses, Provincial Hospital, Fairville, N.B.

WANTED

An **Operating Room Supervisor** is required for a 150-bed hospital in **Western Ontario.** Applicants with post-graduate experience and teaching ability are preferred. State salary and references. Apply in care of:

Box 4, The Canadian Nurse, 1411 Crescent St., Montreal, P.Q.

WANTED

Applications are invited for the position of **Surgical Nurse** for December 1 to take charge of **Operating Room** in a 36-bed hospital. Postgraduate experience and ability to assist the surgeon are necessary. State experience and salary required.

A nurse is also required for a small **maternity ward** of 10 bassinettes. State experience and salary required. Eight-hour day and six-day week. Apply to:

The Matron, Kimberley Hospital Society, Kimberley, B.C.

WANTED

A **Nurse Superintendent** and **three other nurses** are required for duty in the **Huntingdon County Hospital.** Apply by letter to:

Mr. E. C. Martin, Secretary, The Huntingdon County Hospital, Huntingdon, P.Q.

The following nurses have been awarded Victorian Order scholarships for study in public health nursing and are on leave of absence from the Order: *Olive Bell, Vera Clark, Ruth Coldham, Allison Dilts, Geraldine Garnett, Kathlyn Macdonell, Margaret MacLaren, Normina MacLean, Elsie Schuman,* and *Betty Short.*

Marjorie Baird, formerly supervisor of the Border Cities Branch, has been appointed nurse-in-charge of the Victoria Branch.

Frances Docker has been transferred from the Napanee Branch to take charge of the Burlington Branch.

Mary Morrison has been transferred from the Kingston staff to take charge of the Napanee Branch.

Evelyn Oldershaw has been transferred from the East York staff to the Burnaby staff.

Pauline Roger has been transferred from the Lachine staff to the Sherbrooke staff.

Olga Friesen has been transferred from the Toronto staff to the Kitchener staff.

M.L.I.C. Nursing Service

Gilberte Patry (Notre Dame Hospital, Montreal, and University of Montreal public health nursing course) has been transferred from Shawinigan Falls to the Quebec City nursing staff.

Madeleine Cadieux (Sacred Heart Hospital, Hull, and University of Toronto public health nursing course) has been transferred to Shawinigan Falls, where she will replace Gilberte Patry as Metropolitan nurse.

Olive Carrier (St. Mary's Hospital, Montreal) is taking the public health nursing course at the University of Montreal. Miss Carrier was granted a Metropolitan scholarship to assist her in this course.

Eugenie Tremblay (Notre Dame Hospital, Montreal, and University of Montreal public health nursing course) has been transferred from Riviere du Loup to the McGill nursing staff in Montreal.

Claire Champagne (Ste. Justine Hospital, Montreal, and University of Montreal public health nursing course) has been transferred from Montreal to Riviere du Loup where she will replace Eugenie Tremblay as Metropolitan nurse.

NEWS NOTES

MANITOBA

Winnipeg General Hospital:

Betty Mackay is in charge of the public health field at Arden, succeeding Flora Sigurdson, who has joined the R.C.N. Nursing Service. Miss Mackay was formerly with the social service department at the W.G.H. Ruth Stratton is with the City Health Department, Winnipeg. Frances Waugh has been appointed science instructress in the Grace Hospital School of Nursing. Pat Bateman is on temporary duty in the hospital at Norway House. Martha Newhouse and Sheila McWhirter are doing general duty at the Vancouver General Hospital. Morna Kenny has joined the R.C.A.M.C. Nursing Service.

Mary Eichel is taking a postgraduate course in surgery at the Royal Victoria Hospital. Anna Spence is taking a postgraduate course in public health nursing at the University of Minnesota. Dorothy Hibbert and Irene Cooper are taking a postgraduate course in ward supervision and administration at the University of Manitoba. W. Clayton is taking a postgraduate course in public health nursing at the University of Manitoba. Allison Dilts, Normina McLean, and Geraldine Garnett, from the V.O.N., Winnipeg, are taking the postgraduate course in public health nursing offered at the McGill School for Graduate Nurses.

NEW BRUNSWICK

SAINT JOHN:

Alice Carney and Marion McGowan have recently returned from military nursing service in South Africa. Miss Carney is now in the R.C.A.M.C. Nursing Service and Miss McGowan has recently been married. After taking a postgraduate course at the Royal Victoria Hospital, Montreal, Marjorie Clark has joined the staff at the Saint John General Hospital. Erna Hartz is taking a postgraduate course in Toronto. Kathleen Bell is taking a course in clinical supervision and surgical nursing at the McGill School for Graduate Nurses. Muriel McConnell is doing public health in Portage la Prairie. All these nurses are graduates of the School of Nursing of the Saint John General Hospital.

ONTARIO

DISTRICT 5

Toronto General Hospital:

Grace Giles has been appointed chief instructor in the School of Nursing of the

Toronto General Hospital. She has had wide and valuable experience which includes general duty nursing. After taking a course in teaching and supervision at the University of Toronto School of Nursing Miss Giles accepted a position as assistant head nurse and later was appointed assistant instructor in the teaching department. Miss Giles then joined the nursing staff of the Port Arthur General Hospital and later returned to the University of Toronto and obtained her B.A. She then was appointed to the teaching staff of the Vancouver General Hospital and during the past year has pursued her studies for her Master's degree by doing work in zoology with Dr. Norma Ford.

Marion E. Markle has been appointed to the position of medical supervisor. She recently returned after having taken a postgraduate course at Columbia University. She also had some field work experience at Henry Street and observed in the Neurological Institute of the Presbyterian Centre.

Carol Adams has accepted the position of operating room supervisor. She also has spent the past year in postgraduate study at Columbia University and, before returning to Canada, had a period of observation in the operating rooms of several large American hospitals.

Evelyn Robson has been appointed to the teaching staff of the School of Nursing of the T. G. H. She has just completed a course at Columbia University and has observed in the teaching departments of several American schools.

Toronto Western Hospital:

Miss Beatrice L. Ellis, superintendent of nurses and principal of the Training School of the Toronto Western Hospital, was honoured at a reception recently given by the Board of Governors, the Women's Board, the Alumnae Association, and the officers of the hospital on the occasion of her retirement.

Miss Gladys J. Sharpe, formerly matron of the Toronto Military Hospital and of Camp Borden Military Hospital, succeeds Miss Ellis as acting superintendent of nurses and principal of the Training School. Miss Mary Ingham, formerly superintendent of nurses at the Moose Jaw General Hospital, has been appointed as assistant to Miss Sharpe.

Miss Rahno Beamish, formerly assistant superintendent of the Training School of the Toronto Western Hospital, has accepted a position as superintendent of nurses and principal of the Training School of the St. Thomas General Hospital.

Elsie Murphy, Mildred Puckering, and Muriel Sutton have joined the R.C.A.M.C. Nursing Service. Doris Armstrong has joined the R.C.N. Nursing Service.

QUEBEC

Montreal General Hospital:

Miss Holt and her staff entertained at tea recently in honour of Betty Scott who has joined the R.C.A.M.C. Nursing Service, Elizabeth Kydd, who has resigned from the staff to be married, and Miss K. Clifford. Suitable gifts were presented to each one.

K. Clifford, Mildred Brogan and Ruth Francis are taking the course in teaching and supervision at the McGill School for Graduate Nurses.

Clara Jackson has accepted an appointment as superintendent of the General Hospital, Collingwood, Ontario. Gladys Leslie is acting instructor of nurses in the General Hospital, St. Johns, Newfoundland. Mrs. Todd (Marion Cole) has taken up school nursing in South Carolina. Margaret Todd has been appointed to the Nursing Service of the American Navy. Mrs. Hecht (Miss Kobayashi) is on the staff of the social service department of the Royal Edward Institute. Bernice Connor and Miss Chornobry have been appointed to the staff of the Central Division.

Royal Victoria Hospital:

Rose Anne Bolton is now assistant in the urological department, and B. Stewart is on the staff of the out-patients department. Bernice White has joined the staff of the Alexandra Hospital. Evelyn Wade is now in the x-ray department. Jean MacKenzie has joined the R.C.A.M.C. Nursing Service.

McGill School for Graduate Nurses:

A large number of students have registered at the School this year—all Provinces are represented and all courses are being taken. We wish them much success in their studies.

Laura Lambe (T. & S., 1936) has resigned from the staff of Nicholls Hospital, Peterborough, and is now at the Women's College Hospital, Toronto. Katherine Weatherhead (T. & S., 1942) has resigned from the teaching staff of the Winnipeg General Hospital, and is now taking the National Office short course with the V.O.N. in Montreal. Nancie Methuen (P.H.N., 1942) has resigned from the Health Unit at Stettler, Alberta, and is now with the V.O.N. in Montreal on relief duty. Lillian Pettigrew (P.H.N., 1939) has resigned from the V.O.N. in Toronto and is now on the teaching staff at the Winnipeg General Hospital as public health nurse.

Helen M. Smith (P.H.N., 1932 & Teaching, 1933) visited the School recently.

Official Directory

International Council of Nurses

Executive Secretary, Miss Anna Schwarzenberg, 310 Cedar Street, New Haven, Connecticut, U. S. A.

THE CANADIAN NURSES ASSOCIATION

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Nova Scotia: (1) Miss M. Jenkins, Children's Hospital, Halifax; (2) Sister Catherine Gerard, Halifax Infirmary; (3) Miss Jean Forbes, 412 Tower Rd., Halifax; (4) Miss M. Ripley, 46 Dublin St., Halifax.

Ontario: (1) Miss Mildred I. Walker, Institute of Public Health, London; (2) Miss Dora Arnold, Brantford General Hospital; (3) Miss Winnifred Ashplant, 807 Waterloo St., London; (4) Miss Stella Murray, Niagara-on-the-Lake.

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Quebec: (1) Miss Eileen Flanagan, 3501 University St., Montreal; (2) Rev. Soeur Décary, Notre Dame Hospital, Montreal; (3) Mlle Marie Cantin, 4852 St. Denis St., Apt 3, Montreal; (4) Miss Effie Killins, 3533 University St., Montreal.

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General Secretary, Miss K. W. Ellis, National Office, 1411 Crescent St., Montreal, P.Q.

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. . . OFF . . . DUTY . . .

The other evening we went to see "So Proudly We Hail" . . . a moving picture which tells the story of the American nurses who served with devotion and courage in the Bataan peninsula . . . Having previously read the comments made by the professional movie critics . . . we had a fair idea of its propaganda value . . . so all we had to do was appraise it from a purely nursing point of view . . . Many scenes appealed to us tremendously . . . but there were a few that reminded us of Lewis Carroll's account of the conversation between the Walrus and the Carpenter . . . "The Carpenter said nothing but the butter's spread too thick" . . . This opinion contradicts that of the critic who liked the picture . . . "because it made even trained nurses seem human" . . . a reaction that may have been due to the combined impact on the susceptible male mind, of Claudette Colbert, Paulette Goddard and Veronica Lake . . . However, we later discovered another critic who was made of sterner stuff . . . his idea seemed to be that the total effect was weakened . . . because the picture was neither a documentary film nor the usual Hollywood hokum . . . but rather a dull mixture of these two incompatibles . . . Apparently he would have been quite willing to leave a lot of Claudette Colbert's profile on the cutting room floor . . . and perhaps to telescope the interminable love scenes . . . Incidentally, we were delighted to find that several young and lovely nurses entirely agreed with him on this point . . . In spite of these carping criticisms, we still think the picture was a good one . . . We liked Paulette Goddard in her black glamour nightgown . . . though she was even better in G. I. slacks and pigtails . . . We found to our immense surprise that Veronica Lake could look, and behave like a nurse (if not a human being) . . . That was a grand scene in the ward of Japanese wounded . . . when she realized she could not take the cold and calculated revenge she had counted on . . . "I couldn't kill a wounded rat" . . . No, no nurse could . . . The Caesarean section was played up too much . . . but the response to the cry of the new-born child was true and poignant . . . No nurse ever hears it unmoved . . . It is always as though one heard it for the first time . . . The utter brutality of the bombing sequence was perfectly justified . . . if flesh and blood has stood up to the reality for five long years . . . we ought not to flinch at a shadow on a screen that tries to tell us how it feels . . . Even though this picture failed to tell the whole story of Bataan . . . it has dignity and courage and humour . . . We can't help wondering what sort of a documentary film our Canadian National Film Board could do if Grierson were given a free hand . . . There would be nurses in an Arctic outpost . . . army nurses in Sicily . . . a public health nurse who hasn't quite rehabilitated the family . . . a tired night supervisor, wearily gathering up the reports just as dawn begins to break . . . a private nurse keeping a lonely vigil beside the only light in the darkened house . . . If we had our way . . . there would be no talking . . . just a background of music . . . sometimes grave, sometimes gay, sometimes triumphant, sometimes heavy with defeat . . . music that would be the very soul of nursing.

— E. J.

VOLUME 39
NUMBER 12

DECEMBER
1943

On Christmas Eve

Courtesy of
Grenfell Labrador Medical Mission

See page 784

QUESTION: *Which of the essential nutrients is most frequently involved in nutritional failures?*

ANSWER: It is not possible to incriminate any one of the essential nutrients as being most frequently responsible for nutritional failure (1). Some ten or more nutrients have been reported as being the first limiting factor in various dietary regimes followed in this country. However, the deficiency considered to be most serious varies from one section to another, and even with the nutrient receiving the most attention at the moment.

Although opinion regarding the specific nutrient most frequently supplied in inadequate amounts varies, it is generally agreed that inclusion of liberal quantities of the "protective" foods in the diet should be the basis of any programme designed to eliminate malnutrition (1, 2). In diets designed to supply liberal amounts of the essential nutrients many of the readily available economical canned foods may well be included.

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(1) 1939, Food and Life; Yearbook of Agriculture, U. S. Dept. of Agriculture, U. S. Gov't Printing Office, Washington, D. C.
1939, U. S. Dept. Agr. Circular No. 507.

(2) 1941, U. S. Public Health Reports 56, 1233.
1940, J. Am. Med. Assn. 114, 548.
1938, Ibid—111, 1846.
1938, J. Am. Dietet. Assn. 14, 1.
1938, Ibid—14, 8.

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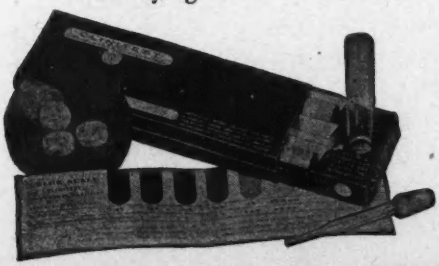

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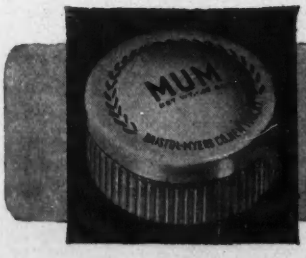

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